UNIVERSITY OF THE
PACIFIC

Intake Form

Patient Name ______________________________ Date_____ /_____ /______
First Last MI MM DD YYYY

Address ____
Street City State Zip

Home Phone ____________________ Cell Phone ____________________

Email ____________________ Sex ☐ M ☐ F

Date of Birth ____________________ Marital Status ☐ Married ☐ Single

Emergency Contact ____________________ Phone ____________________

Relationship to Patient ____________________

Primary Care Physician ____________________ Phone ____________________

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient ____________

☐ Advertisement ☐ Insurance ☐ Referred by Physician ____________

☐ Consumer Seminar ☐ Employer ☐ Other ____________

Check the boxes and sign below

☐ I agree I am ultimately responsible for the balance of my account for services rendered.

☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.

☐ I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, employers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ The FDA has determined it is in my best interest to have a medical evaluation by a licensed physician (preferrably a physician who specializes in diseases of the ear) before purchasing hearing aids. I have been advised by the practice and/or its agents about this determination and hereby waive this requirement.

☐ I give permission to receive newsletters or information about upcoming events, specials and articles pertaining to services or products in the clinic.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

______________________________ ____________
Patient Signature Date

______________________________ ____________
Legal Guardian if Patient is a Minor Date

When was your last hearing exam? ______________________ By whom? ______________________

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 5–10 Years ☐ 10+ Years

Have you ever utilized hearing aid(s)? ☐ Yes ☐ No If yes, describe your satisfaction ______________________

____

Which ears? ☐ Right ☐ Left ☐ Both ears

Make ______________________ Model ______________________

Who recommended the hearing aids(s)? ______________________

How many hours a day do you wear your hearing aid(s)? ______________________

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when _________ Which ear ________ Name of procedure ____________

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No Do you suffer from dizziness? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No Do you have a family history of hearing loss? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No

If yes, please list ____

Do you have a history of any of the following? ☐ Measles ☐ Mumps ☐ Diabetes ☐ Pneumonia

☐ Frequent Headaches ☐ High Fevers ☐ Meningitis ☐ Other (describe) ______________________

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other (describe) ____________

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

What are the top 3 environments you would like to hear better in? SCALE OF 1-4 PRE POST

1. ____ _______ _______

2. ____ _______ _______

3. ____ _______ _______

Are there any specific features you are interested in for your hearing aid(s)? ______________________

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