McLean Hearing Center
6160 Sherry Ln. Suite 100
Dallas, TX. 75225
Tel # 214-363-4955
Fax # 214-363-4970

# PATIENT INTAKE FORM

## Patient Information

Last Name: ________________________________ First Name: ______________________________ Birth date: ____________

Age: _________ Sex: M F Email Address: ________________________________________________________________

Address: _______________________________________________________________________________________________
STREET APT # CITY STATE ZIP

Home Phone: __________________________________ Work Phone: ______________________________________________

Cell Phone: _____________________________________________________________________________________________

How would you like to be contacted: ❍ Home Phone ❍ Email ❍ Cell Phone ❍Mail ❍ Work Phone

Occupation: _____________________________ Employer/Business Name: _________________________________________

Primary Insurance: ______________________________ Secondary Insurance: ______________________________________

Emergency Contact Name/Number: ___________________________________________________________________________

Marital status: Single / Married / Divorced / Widowed Spouse's Name: _________________________________________

## Referred By

We like to know how our patients find us. Please check the MOST influential sources of information about this practice:

❍ Physician ❍ Family Member ❍ Vocational Rehabilitation ❍ Newspaper ❍ Friend/Co-worker ❍ Internet

❍Audiologist ❍ Yellow Pages ❍ Hospital Referral Service ❍ Seminar ❍ Health Plan ❍ Other

Name of Referral (if applicable): ______________________________________________________________________

## Insurance

In order for us to file your insurance claim for you, the following must be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. Further, I authorize payment of medical benefits to be made directly to McLean Hearing Center for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

______________________________________________________ ___________________________________

Patient/Parent/Guardian Signature Date

## Release of Medical Information

I, ___________________________, hereby authorize McLean Hearing Center to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed on the succeeding page. I would like to have this information forwarded to: ______________________________________________________________________

______________________________________________________ ___________________________________

Patient/Parent/Guardian Signature Date

I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices. _________________ Initials

## Medical History Information

Primary Care Physician (PCP):_________________________________ Phone: __________________________________

Please check the any of the following that you currently have or have had in the past:

| | | | |
|---|---|---|---|
| ❍Bell's Palsy | ❍Hepatitis A | ❍Parkinson's | ❍ Other ____________________ |
| ❍Diabetes | ❍Hepatitis B | ❍Sinusitis | |
| ❍HIV/AIDS | ❍Hepatitis C | ❍Stroke/TIA | |
| ❍Head Injury | ❍Heart Trouble | ❍Cancer _______________ (Type) | |
| ❍High Blood Pressure | ❍Neurological Symptoms | Radiation? ❍ Yes ❍ No<br>Chemotherapy? ❍ Yes ❍ No | |

Have you ever had surgery that may have affected your hearing? ❍ Yes ❍ No

Do you have a pacemaker? ❍ Yes ❍ No

Do you have a history of ear infections? ❍ Yes ❍ No ❍ As a child ❍ As an adult

Is there a history of hearing loss in your family? ❍ Yes ❍ No If so, who? __________________________________

Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo? ❍ Yes ❍No
If yes, please describe: ________________________________________________________________________________

Do you take any prescription medications on a regular basis? Please list below:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Do you take any Aspirin or any blood thinners? ❍ Yes ❍ No If yes, name of medication _____________________

Have you seen an Ear, Nose and Throat Physician? ❍ Yes ❍ No

If so, when was your last visit? ______________________ Name of Physician: ____________________________

Have you received prior hearing care? Yes No

Name/Location of previous Hearing Professional: _________________________________________________________

Have you ever had any type of ear surgery? ❍ Yes ❍ No

Have you ever been diagnosed with a deformity of the ears? ❍ Yes ❍ No

Do you have tubes in your ears? ❍ Yes ❍ No

Do you have any pain in your ears? ❍ Yes ❍ No

Have you had drainage from either ear in the last 90 days? ❍ Yes ❍ No

When was your last hearing test completed? ______________________________________________________________

## Hearing Needs Assessment

Main Concern:

- ❍ Hearing Loss: _______Right Ear ______Left Ear
- ❍ Difficulty Hearing: ______In Quiet ______In Noise
- ❍ Tinnitus/Ringing or Buzzing in your ears
- ❍ Telephone: ______Right Ear ______Left Ear
- ❍ Dizziness

How long have you noticed this difficulty? _______________________________________________________________

Is the difficulty due to a work-related injury/exposure? ❍ Yes ❍ No

If so, date of injury: ______________________ Explain: ______________________________________________

Do you feel your hearing is changing? ❍ Yes ❍ No Is this change: ❍ Gradual ❍ Sudden

Have you been exposed to loud noise, either recently or in the past?

❍ Yes ❍ No

- ❍ Farm Machinery
- ❍ Power Tools
- ❍ Music
- ❍ Military
- ❍ Hunting/Shooting
- ❍ Jet Engines
- ❍ Factory Noise
- ❍ Other ___________________________

Please rank the following in order of importance (1-4 with 1 being most important and 4 being least important), if a hearing aid is recommended for you:

_____ Sound Quality and Clarity

_____ Durability and Reliability

_____ Cost

_____ Appearance

What is your hearing aid(s) experience?

- ❍ I have a hearing device(s) and regularly use them in my ❍ right ear ❍ left ear
- ❍ I have a hearing device(s), but: ❍ do not use them ❍ use them occasionally
- ❍ I tried a hearing device(s), but did not like it.
- ❍ I have inquired about a hearing device(s) in the past, but did not purchase.
- ❍ I have never used a hearing device(s)

On a scale of 1-10, how motivated would you say that you are (emotionally, psychologically, financially, etc.) regarding taking steps toward better hearing? (please circle one)

Not Motivated 1 2 3 4 5 6 7 8 9 10 Very Motivated

Please rate your hearing in the following situations:

| Situation | How Well I Hear | | | How Often I am In Situation | |
|---|---|---|---|---|---|
| | POOR | FAIR | WELL | RARELY | OFTEN |
| *Telephone* | | | | | |
| *Meetings* | | | | | |
| *Workplace* | | | | | |
| *Church* | | | | | |
| *Television* | | | | | |
| *Car* | | | | | |
| *Restaurants* | | | | | |
| *Large Social Settings* | | | | | |
| *Quiet Room* | | | | | |

**This Section for Office Use Only:**

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