STANWOOD HEARING

9300 271st St NW, Suite B-5 | Stanwood, WA 98292 | (360) 572-4422

Name:_____

Age:_____ Date:_____

Occupation (*current or past*):_____

PATIENT INFORMATION

Legal Name: _____ DOB: ____/____/____ Age: _____
First Initial Last

Preferred Name: _____ Gender: Male Female Marital Status: S M W

Spouse or Significant Other's name: _____

Address: _____
Street City State Zip

Winter Address: _____
Street City State Zip Approx. Dates

Home Telephone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____ Employer: _____

☐ I would like to receive electronic correspondence from Stanwood Hearing, including newsletters and other information.

In case of emergency, please contact: Name:_____ Relationship: _____

Telephone: (_____)_____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF THE PATIENT IS UNDER 18 YEARS OF AGE

Father's Name:_____
Date of Birth:_____
Home Phone:_____
Work Phone:_____
Employer:_____

Mother's Name:_____
Date of Birth:_____
Home Phone:_____
Work Phone:_____
Employer:_____

Who is your primary care physician? _____

City: _____ Clinic: _____ Phone: (_____)_____

☐ I authorize the release of my medical information to my physician. Signature:_____

Who referred you to our office?

We like to know how our patient's find our Clinic. If your physician, a family member, or a friend recommended us, we want to thank them. If you heard of us through another source, it is helpful for us to know that as well. Please indicate the MOST influential source(s) of information you have obtained about us below. If you were referred by your physician, an Audiologist, family member, or friend, we ask that you provide their name. Thank You!

☐ Physician ☐ Phonebook ☐ Health Plan/HMO ☐ Audiologist
☐ Family Member ☐ Friend ☐ Attended Seminar ☐ Internet
☐ Newspaper ☐ L&I ☐ Sign ☐ Other:_____

If applicable, please provide the name of the person who referred you to us:_____

INSURANCE INFORMATION

ID Number: _____ Plan Name: _____

*** Please provide your insurance identification card when submitting this form.***

As a courtesy, we are happy to submit an insurance claim on your behalf. 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 Stanwood-Camano Hearing Center for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself. I understand that preliminary estimates of insurance coverage are not guaranteed until formally processed by my insurer, and I am financially responsible for any unpaid balance.

_____ _____/_____/_____
Patient/Parent/Guardian Signature Date

STANWOOD HEARING

9300 271st St NW, Suite B-5 | Stanwood, WA 98292 | (360) 572-4422

Name:_____

Age:_____ Date:_____

Occupation (*current or past*):_____

PRIMARY CONCERN

☐ Hearing Loss: ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Tinnitus (ringing): ☐ Right Ear ☐ Left Ear ☐ Constant ☐ Intermittent

☐ Other (*explain*): _____

_____

How long have you had these concerns? _____

MEDICAL HISTORY

YES NO

Will this be your first hearing evaluation? *If no, when and where was the last evaluation done?* _____

Have you ever had ear surgery? *If yes, please explain:* _____

Is this a work-related injury or noise exposure? *If yes, date of injury or exposure:* _____

Please explain: _____

Do you have a known ear condition? *If yes, explain:* _____

Have you ever experienced a sudden change in hearing? *If yes, explain:* _____

Do you ever have ear pain? *If yes, explain:* _____

Do you ever experience dizziness/light headedness? *If yes, explain:* _____

Has a doctor ever had to remove wax from your ear? *If yes, when?* _____

Is there a history of hearing loss in your family? *If yes, who and cause?* _____

Do you have a history of ear infections? *If yes, when?* _____

Do you hear better in one ear? *If yes, which?* _____

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

☐ Arthritis ☐ Diabetes ☐ HIV or AIDS ☐ Scarlet Fever

☐ Asthma ☐ Head Injury ☐ Measles or Mumps ☐ Sinusitis

☐ Bell's Palsy ☐ Heart Conditions ☐ Meningitis ☐ Stroke/TIA

☐ Cancer ☐ Hepatitis ☐ Neurological Disorders ☐ Vision Loss

☐ CMV ☐ High Blood Pressure ☐ Parkinson's/Tremors ☐ Other:_____

Are you currently taking any medications on a regular basis? *If so, please list below or provide a list to copy:*

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Have you ever been exposed to loud noise, either currently or in the past? ☐ YES ☐ NO

If yes, what type? ☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise

☐ Power Tools ☐ Military ☐ Jet Engines/Aircraft ☐ Other:_____

Continued on next page →

HEARING HISTORY

WITHOUT HEARING INSTRUMENTS			WITH HEARING INSTRUMENTS *(if applicable)*	
YES	NO		YES	NO
		Do you find yourself asking people to repeat what they have said?		
		Do you have more difficulty hearing if you cannot see the speaker?		
		Do you have more difficulty understanding in background noise?		
		Do others comment that the TV volume is too loud?		
		Do you sometimes hear the words without understanding them?		

LISTENING SITUATIONS

In which situations would you like to hear better? *Please check all that apply.*

- ☐ One-on-one Conversations
- ☐ Religious Services
- ☐ Large Groups
- ☐ Small Groups
- ☐ Workplace
- ☐ Car
- ☐ Outdoors
- ☐ Telephone
- ☐ Meetings
- ☐ Movie/Theatre
- ☐ Restaurants
- ☐ Television
- ☐ Other situations: _____

HEARING PREFERENCES AND EXPECTATIONS

Hearing in Quiet:	☐ Extremely Important	☐ Slightly Important	☐ Neutral	☐ Not Important
Hearing in Noise:	☐ Extremely Important	☐ Slightly Important	☐ Neutral	☐ Not Important
Cost of Instrument:	☐ Extremely Important	☐ Slightly Important	☐ Neutral	☐ Not Important
Cosmetic Appearance:	☐ Extremely Important	☐ Slightly Important	☐ Neutral	☐ Not Important

How confident are you in your knowledge regarding hearing instrument technology?

☐ Very Confident ☐ Somewhat Confident ☐ Neutral ☐ Not Confident

How much benefit do you expect to gain from hearing instruments?

☐ Significant Benefit ☐ Moderate Benefit ☐ Some Benefit ☐ Little/No Benefit

How motivated are you to wear hearing instruments?

☐ Highly Motivated ☐ Slightly Motivated ☐ Neutral ☐ Not Motivated

How confident are you that you will be successful with hearing instruments?

☐ Very Confident ☐ Somewhat Confident ☐ Neutral ☐ Not Confident

HEARING INSTRUMENT PREFERENCES

Would you prefer hearing instruments that:

- ☐ Automatically adjust to different listening environments and have no manual controls.
- ☐ Allow you to manually adjust the volume and make program selections.
- ☐ Not sure or would like more information.

If the results of your hearing assessment show that hearing instruments would be beneficial, how ready are you?

Please rate your readiness on this 1-10 scale by circling one number below:

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

CURRENT HEARING INSTRUMENT USERS

How long have you worn hearing instruments? _____ Do you wear one or two? _____

How old are your current hearing instruments? _____ How often do you wear them? _____

What do you like about your current hearing instruments? _____

What areas would you like to see improvement? _____

THANK YOU!