sound hearing Care

Simpsonville | Greer | Greenville

Welcome to Sound Hearing Care, we want to provide you excellent hearing healthcare.
Please tell us a little about yourself by completing as much as possible on both sides of this form.

How did you hear about us? _____

PERSONAL INFORMATION

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

TELEPHONE (HOME) _____ (WORK)_____

MOBILE PHONE_____ DATE OF BIRTH _____ AGE_____

MALE_____ FEMALE_____ MARITAL STATUS _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

NAME & PHONE # OF EMERGENCY CONTACT_____

EMAIL ADDRESS: _____ May we contact you via email? YES_____ NO ____

INSURANCE INFORMATION – PLEASE REVIEW & INITIAL

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.
If health insurance is not in your name, please provide the following information:

_____ _____
Name of insured Relationship to patient

_____ _____
Insured's Date of Birth Insured's Employer if Applicable

I hereby authorize Jennifer Waddell, HIS and her associates to furnish information to my insurance carrier concerning my hearing and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE_____ DATE_____

PLEASE REVIEW & INITIAL

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➡

Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

MEDICAL HEARING/HISTORY

Do you have pain/discomfort in your ear? NO___ Right ___Left ___Both ____

Do you have you any drainage in your ear? NO___ Right ___Left ___Both ____

Do you have a history of ear infections? NO___ Right ___Left ___Both ____

Do have ringing or other noises in your ear? NO___ Right ___Left ___Both ____ Constant OR intermittent?

Have you ever had ear surgery? NO___ Right ___Left ___Both ____

Please describe_____

Do you have dizziness or vertigo? Yes_____ No _____

Do you think you have a hearing loss? Yes_____ No_____

Have you had your hearing tested before? Yes_____ No_____ When_____ Results_____

Is there a family history of hearing loss? Yes_____ No_____ If yes, who: _____

Have you had noise exposure? Yes_____ No_____
If yes, from work/military/hobbies, etc., please specify _____

Do you currently use a hearing aid? Yes_____ No_____
If yes, How long? _____ What type? _____ Satisfied with instrument? Yes____ No____

Have you seen your physician regarding any of the above? _____

Please describe other medical conditions we should be aware of: _____

PLEASE REVIEW & INITIAL

LISTENING SITUATIONS	How well do you hear in this situation?			How often are you in this situation?		
	POOR	FAIR	WELL	OFTEN	SOMETIMES	RARELY
Television						
Music						
Restaurant						
Church						
Meeting/Lecture						
Work Place						
Telephone Conversation						
Car						
Large Social Gathering						
Quiet Conversation (1-2persons)						

NOTES / MISCELLANEOUS **(additional information that may be pertinent)**