**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Nickname**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your Phone #, then check which # you prefer to be contacted: **Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Home**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□ Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□ Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are we allowed to leave a descriptive message on the phone numbers provided** **□ YES □ NO**

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State**:\_\_\_\_\_\_\_\_\_\_ **Zip**:\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact and Phone** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information: (we will also copy insurance cards at your appointment)**

***Primary Insurance***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Member ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group** # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: (if not the same as patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Secondary Insurance***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Member ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group** # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: (if not the same as patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you experienced or been diagnosed or treated for: (mark the box)**

□ Hearing Loss □ Facial tingling

□ Right Ear □ Left ear □ Both ears □ Dizziness

□ Gradual □ Sudden □ Fluctuating □ Dizziness with nausea

□ Currently wear a hearing device □ Dizziness with vomiting

□ Interested in a hearing device □ Dizziness with noises in your ears

□ Hear noises/ringing in your ears/head □ Unsteadiness

□ Right ear □ Left ear □ Both ears □ Off balance / falls

□ Constantly □ Occasionally □ Rarely □ Ear Surgery

□ Exposure to loud noises □ Depression

□ Ear Pain □ Anxiety

□ Ear Drainage □ Diabetes

□ Ear wax buildup □ Taking blood thinners

□ Fullness or stuffiness in your ears □ Sinusitis

□ Facial numbness □ Family history of hearing loss

□ Facial weakness

**Explanations can be written can on back side of this sheet, if needed**

List Current Medications or vitamins: (Or provide list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legally Responsible Person Date