Ascent HEARING CENTER
1181 Wantagh Ave. • Wantagh, NY 11793
PHONE (516) 785-3292 • **FAX** (516) 785-3296

Confidential Patient Information

1 Patient Information

Name:_____ DOB:_____Age:_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Nearest Family Member Name:_____ Phone: _____

Marital Status: ☐Single ☐Widowed ☐Married ☐Other Name of Spouse: _____

Occuptaion: _____ If retired, past occupation: _____

Primary Insurance: _____ Insured Name:_____ DOB: _____

Secondary Insurance: _____ Insured Name:_____ DOB: _____

How did you hear about us? ☐Patient ☐Newspaper ☐Direct Mail ☐Community Event ☐Physician Referral ☐Website
☐Other: _____

2 Medical History

Name of Primary Care or Referring Physician: _____

Physician's telephone number: _____Fax: _____

May we release a copy of your test to your physician? ☐ Yes ☐ No

☐Yes ☐No Do you have an ENT?: Name: _____

☐Yes ☐No Have you ever had ear surgery? Have you ever had cancer?: ☐Yes ☐No

☐Yes ☐No Are you diabetic? Do you have a latex allergy?: ☐Yes ☐No

☐Yes ☐No Are you taking blood thinners?: Do you wear a pacemaker?: ☐Yes ☐No

☐Yes ☐No Do you have any medical conditions?

☐Yes ☐No Do you have arthritis? If yes, where: _____

☐Yes ☐No Prescription drugs: If yes, please list: _____

_____

3 About Your Hearing

☐Yes ☐No Have you ever had your hearing tested:
By whom: _____

☐ Which ear do you use to answer the telephone?
☐Right ear ☐Left ear

Which is your poorer ear?
☐Right ☐Left ☐ Same

☐Yes ☐No Do you have a history of noise exposure?

☐Yes ☐No Do you have tinnitus?
☐Right ear ☐Left ear ☐Both

☐Yes ☐No Have you seen a doctor for wax removal?

☐Yes ☐No Does anyone else in your family have a hearing problem? Who? _____

In what environment does your hearing problem give you the most trouble? _____

☐ I have a hearing aid and use it regularly in my:
☐Right ear ☐Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete backside →

5 Hearing Needs Assessment

Put a "1" before the one thing that is most important to you in purchasing a hearing aid.
Now put a "2" before the second most important thing to you when purchasing a hearing aid.
Next, put a "3" before the third most important thing to you when purchasing a hearing aid.
Lastly, put a "4" before the least important thing to you when purchasing a hearing aid.
(Remember to use a 1 , 2 , 3 and a 4.)
These are your choices:

_____ Sound Quality & Clarity ____ Durability/Reliability ___ Cost ____ Appearance

6 Motivation

What motivated you to come in today?_____

_____

_____

7 Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated . . . . . **Very Motivated**

8 Self Questionnaire

Please answer "yes, "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

9 HIPPA Release & Authorization

☐ By checking this box and signing below, you allow Ascent Hearing to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are not covered and thus not paid to Ascent Hearing by your insurance carrier(s) for services rendered by our office.
This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: _____ Date:_____