

West Newton Hearing Center – Client Intake Form

Date _____

Name _____ Date of Birth _____ Age _____

Address _____
(Number & Street) (City) (Zip code)

Home Phone _____ Cell Phone _____

Client Email Address _____ May we contact you by email? Y or N

Occupation _____ Employer _____ Business Phone _____

In case of emergency contact _____ Phone _____

How were you referred to our practice? _____

Primary Care Doctor _____

**Doctor's
Address/Phone** _____

INSURANCE INFORMATION*

We will take copies of your insurance card(s). Please give card(s) to the front desk.

Insurance Company _____ Member ID # _____

Supplement _____ Member ID # _____

*The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPPA).

I hereby authorize the West Newton Hearing Center to release any information acquired in the course of my exam to my physician and to the appropriate insurance carriers.

Signature _____ Date _____

Patient Name _____

*******PLEASE COMPLETE FOR HEARING PROBLEMS ONLY*******

1. What is your hearing aid experience?

- I have a hearing device and use it regularly on the ___right ear___left ear.
- I have a hearing device, but don't use it, or use it only occasionally.
- I tried a hearing device, but returned it for credit.
- I have inquired about hearing devices at another office(s), but did not purchase at the time.
- I have never used a hearing device.

2. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device.

(1 = Most Important 2 = Important 3 = Somewhat Important 4 = Least Important).
Please use each number only once.

___Sound Quality & Clarity ___Durability/Reliability ___Cost ___Appearance

3. What motivated you to come in today?

4. 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 1 2 3 4 5 6 7 8 9 10 very motivated

Listening Situation	How well do you hear in this situation?		
	Poor	Fair	Good
Television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House of Worship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meetings/Lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone Conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large Social Gathering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quiet Room (1 to 2 people)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: _____

Date: _____

We would like to know how you heard about us!
Please check all that apply.

Primary Care Physician (Name) _____

ENT Physician (Name) _____

Audiologist (Name) _____

Current Patient of Ours (Name) _____

Friend or Relative (Name) _____

Website _____

Online Search (Name search engine) _____

Newspaper (Which paper and when) _____

Magazine (Which magazine and when) _____

Mailing (Type of mailing) _____

Walked by and saw our sign

Health Insurance (Name) _____

Hearing Aid Manufacturer (Name) _____

Other (Describe) _____