HearCare Audiology Center, Inc.

Circle One: Mr. Mrs. Ms. Dr. Name_____

Preferred Name_____ Date of Birth _____/_____/_____ Sex: _____

Florida Address:

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ email _____

Snowbird Information: If applicable.

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ email _____

Circle One:

Employment Status: Full Part-time Unemployed Retired

Marital Status: Married Divorced Single Widowed Other_____

Spouse/Companions/Significant Other's Name: _____

Emergency Contact_____ Phone_____

Primary Care Physician _____ Phone #_____

Please Circle: Do you have…

Family History of Hearing Loss? Yes No Who? _____

Exposure to Noise? Yes No

Dizziness? Yes No Vertigo? Yes No Loss of Balance? Yes No

Ringing? Yes No Buzzing? Yes No Hissing? Yes No

Ear Pain? Yes No Ear Pressure? Yes No Ear Fullness Yes No

How would you rate your hearing on a scale of 1-10 with 1 being the worst and 10 being the best? Please circle one.

1 2 3 4 5 6 7 8 9 10

Present Medications:_____

Medication Allergies? _____

What is the reason for today's visit?_____

How did you hear about HearCare Audiology Center? _____

I understand that I may be responsible for: my deductible, and co-pays, and/or money that my insurance company says that I owe is my responsibility.
I authorize the release of any medical information to my personal physician and to the insurance company if needed to process this claim and related claims.
I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I certify that the above information is correct and that I have read and fully understand.

Signature _____ Date_____