# 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_____**