PATIENT INFORMATION

Name: ______________________________ Date of Birth: ______________
First MI Last

Address: ______________________________

______________________________ ______ ______
City State Zip Code

☐ *Please do* ***NOT*** *send direct mailing from Hear For You Hearing and Balance Center to the address above.*

Home Phone: ______________ Cell Phone: ______________ Marital Status: ______________

Email Address: ______________________________

Employment Status: ______________ Employer: ______________

INSURANCE: ***Please indicate the subscriber on the policy*** ☐ Self ☐ Spouse ☐ Other ______________

If you are the subscriber on the insurance policy please skip this section and proceed to medical information.

Subscriber's Name: ______________________________ Subscriber's Date of Birth: ______________
First MI Last

Policy Holder's Address: ______________________________

______________________________ ______ ______
City State Zip Code

Policy Holder's Phone #: ______________ Employer: ______________

MEDICAL INFORMATION

Primary Care Physician: ______________________________ Location: ______________

Please list any medications you are currently taking: *(List prescriptions including any over the counter prescriptions, herbal, vitamin, mineral, or dietary nutritional supplements)*

Name	Dosage	Frequency	Route/Administered	Name	Dosage	Frequency	Route/Administered

Are you a veteran? ☐ Yes ☐ No Do you receive medical services from the VA? ☐ Yes ☐ No

Do you smoke: ☐ Yes ☐ No Do you experience ringing or hear noises in your ears? ☐ Yes ☐ No

When was your most recent hearing test? ______________________________

Do you currently wear hearing aids? ☐ Yes ☐ No Make: ______________ How old? ______________

Reason for Visit / Communication Difficulties: ______________________________

How did you hear about us? ______________ Who came with you today? ______________

The above information is accurate and to the best of my knowledge.

Patient's Signature: ______________________________ Date: ______________