

General Information:

Full Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____ Date of Birth: _____ Male Female

Marital Status: Single Widowed Married Name of Spouse: _____

Employment Status: Retired Full Time Part Time Occupation: _____

Snowbird Address (if applicable):

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Insurance Information: ***Please allow us to copy your insurance card(s)***

If you are not the primary insured please complete:

Name: _____ Date of Birth _____ Relationship: _____

Medical History:

Primary Physician: _____ Phone: _____

May we send a copy of your hearing evaluation to your Physician? Yes No

Please mark yes/no for all of the following conditions (including past and present conditions):

Diabetes	Self	Family member	None	_____
Hypertension	Self	Family member	None	_____
Thyroid problems	Self	Family member	None	_____
Heart Problems	Self	Family member	None	_____
Cancer	Self	Family member	None	_____
Hearing Loss	Self	Family member	None	_____

Please list any current medications, specifically blood thinning meds _____

About your Ear

Do you have any of the following symptoms?

- Deformity of the ear? Yes No
- Do you have sudden pain in your ears? Yes No
- Sudden or long-term dizziness? Yes No
- Sudden/rapid hearing loss in the past 90 days? Yes No
- Hearing loss in one ear that occurred in the past 90 days? Yes No
- Have you ever had wax removed from your ears? Yes No
- Drainage from either ear in the past 90 days? Yes No
- Which do you believe is your poorer ear? Left Right Not Sure/Same