ADULT HEARING QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____

Have you had any of the following conditions? Briefly explain any that you have checked.

☐ Ear Infections ☐ Ear Surgery (ear tubes, etc.) ☐ Ear Pain ☐ Draining Ears

_____

_____

_____

Was your change in hearing SUDDEN or GRADUAL? ☐ Sudden ☐ Gradual

Do you hear **better** in one ear or the other? ☐ Right Ear Best ☐ Left Ear Best ☐ Both Ears Same

Does your hearing REMAIN CONSTANT or FLUCTUATE? ☐ Remains constant ☐ Fluctuates

Have you experienced any ear pain? ☐ Yes ☐ No _____

Have you experienced ears feeling "stopped up"? ☐ Yes ☐ No _____

Have you experienced any sounds in your head or ear(s)? Ex. Ringing, buzzing, humming, etc.

☐ Yes ☐ No Describe: _____

Have you experienced any dizziness/vertigo? ☐ Yes ☐ No _____

Have you been exposed to loud noise (work, recreation, Military)? ☐ Yes ☐ No _____

Has anyone in your family experienced hearing loss at a young age? ☐ Yes ☐ No _____

Have you ever worn hearing aids? ☐ Yes ☐ No _____

In what situations/environments do you experience the most difficulty hearing?

- _____
- _____
- _____
- _____
- _____

X **Signature:**_____ **Relation to Patient:**_____ **Date:**_____

Ken Martin Audiology

Thank you for choosing Ken Martin Audiology for your hearing healthcare needs! We strive to provide the very best service and appreciate referrals of friends and family if you are satisfied with your visit.

PATIENT INFORMATION

PATIENT'S NAME:		**GENDER:**
PATIENT DATE OF BIRTH:	**AGE:**	
MAILING ADDRESS:		
CITY, STATE, ZIP:		
HOME PHONE #:	**CELL #:**	**WORK #:**
EMAIL:		

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

Some insurance plans (ex. Medicare, Medicaid, CHIP, HMO Plans, etc.) will not pay visit fees if you were not referred by your physician. If you do not have a copy of your insurance or referral in place (if required), self-pay discounts may be available.

HOW HAVE YOU HEARD ABOUT KEN MARTIN AUDIOLOGY? Please check one or more:

- ☐ YOUR PHYSICIAN
- ☐ TELEVISION
- ☐ WALK-IN / STREET SIGNAGE
- ☐ NEWSPAPER
- ☐ WEB SEARCH
- ☐ FACEBOOK / SOCIAL MEDIA
- ☐ HOSPITAL
- ☐ SCHOOL
- ☐ YELLOW PAGES
- ☐ FRIEND / ANOTHER PATIENT: _____

FOR MINORS, NAME OF THE GUARDIAN/PARENT:		
GUARDIAN DATE OF BIRTH:		
ADDRESS, CITY, STATE, ZIP:		
HOME PHONE #:	CELL #:	WORK #:
EMAIL:		

IF THE PATIENT IS LISTED ON ANOTHER PERSON'S INSURANCE, WE MUST HAVE THE PRIMARY POLICY HOLDER'S NAME AND DATE OF BIRTH:

INSURANCE PRIMARY POLICY HOLDER'S NAME: _____

INSURANCE PRIMARY POLICY HOLDER'S DATE OF BIRTH: _____

A COPY OF YOUR INSURANCE CARD(S) AND A PICTURE ID IS REQUESTED ALSO.

X **Signature:**_____ **Relation to Patient:**_____ **Date:**_____

Ken Martin
Audiology

AUTHORIZATION FOR TREATMENT

_____ By initialing here and signing below, I authorize Dr. Ken Martin, Audiologist, to give the referenced patient reasonable and proper audiology care by today's standards. In the event that I am scheduled to receive ongoing procedures, this consent shall remain in effect until I am discharged.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

_____ By initialing here and signing below, I also hereby authorize and direct my insurance carrier to pay directly to Kenneth R. Martin, Jr. any benefits for audiology services rendered to myself/dependent under my insurance plan. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AGREEMENT OR THE INSURANCE I HAVE PROVIDED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ By initialing here and signing below, I acknowledge that I received or been offered a copy of Ken Martin Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I give permission for Ken Martin Audiology to call, text, mail, or email me with information, which may include confidential messages being left on my telephone/answering machine.

_____
Printed Name of patient or personal representative

_____
Signature of patient or personal representative

Date: _____