hearing solutions

724 Front Street
Louisville, CO 80027
Phone: 303-666-8149
Fax: 303-666-9149

Today's Date:_____

PERSONAL INFORMATION

First name: _____ Last name: _____

Date of birth: _____ Gender: _____

Marital status: _____ Preferred language: _____

Address: _____

Email: _____ Place of employment: _____

Home phone: _____ Work phone: _____

Please select your preferred contact method: ☐ Phone ☐ Email

May we leave detailed messages about your hearing healthcare?

Phone: ☐ Yes ☐ No
Email: ☐ Yes ☐ No

How did you hear about us? _____

Primary care physician: _____

May we share test results with your primary care physician? ☐ Yes ☐ No

Emergency contact name: _____ Relationship: _____

Emergency contact phone number: _____

Primary insurance: _____ Secondary: _____

HEARING HISTORY

Please check all that apply:

- ❑ Previous hearing test
  When? _____ Where? _____
  Results: _____
- ❑ Family history of hearing loss
  Who? _____
- ❑ Fluctuating hearing loss
  How often? _____
- ❑ Sensitivity to loud sound
  Which sounds? _____
- ❑ Loud noise exposure
  Describe: _____
- ❑ Use of hearing aids
  What kind? _____
  Are you happy with them? _____

hearing solutions

724 Front Street
Louisville, CO 80027
Phone: 303-666-8149
Fax: 303-666-9149

MEDICAL HISTORY

Please check all that apply:

- ❑ Decreased hearing
- ❑ Tinnitus
- ❑ Fullness feeling in the ears
- ❑ Deformity of the ear
- ❑ Ear drainage (active)
- ❑ Ear surgery
- ❑ Ear pain
- ❑ Dizziness or vertigo
- ❑ Balance problems
- ❑ History of falls
- ❑ History of chronic ear infections
- ❑ Sinus problems
- ❑ Diabetes
- ❑ Other:
- ❑ Serious vision problems
- ❑ History of depression
- ❑ Chemotherapy
- ❑ Compromised immune system
- ❑ High blood pressure
- ❑ Prescription blood thinners
- ❑ Clenching/grinding of the teeth (TMJ)
- ❑ Allergies/hay fever
- ❑ Traumatic brain injury
- ❑ Osteoporosis
- ❑ Cardiovascular disease
- ❑ Cognitive impairment / dementia
- ❑ Smoking

_____

Medications (if you have a list, please let us scan a copy):

_____

_____

Acknowledgement of Receipt Health Insurance Portability & Accountability Act Agreement

I acknowledge I have received a copy of Hearing Solutions Health Insurance Portability & Accountability Act Agreement. I further acknowledge a complete copy of the most current notice is available in the reception area. The undersigned hereby consents to the use of their health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information.

_____

Patient Signature Date

We give sound advice