sound hearing Care

Simpsonville | Greer | Powdersville | Travelers Rest

Welcome! At Sound Hearing Care, our goal is to provide you with excellent hearing healthcare.

Please tell us a little about yourself by completing as much as possible on both sides of this form.

Today's Date _____ **How did you hear about us?** _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

D.O.B. _____ Nickname _____

Address _____ _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

How may we contact you (check all that apply)? _____ Phone ____ Email ___ Text

Male ____ Female ____ Marital Status _____ Occupation _____

Emergency Contact _____ Phone _____

Disclaimer: *Any examination or hearing test provided by Sound Hearing Care is not to be construed as a diagnosis or a medical opinion, nor does it impart to the purchaser a prescription by a person licensed to practice medicine in this State.*

OPTIONAL INSURANCE INFORMATION – PLEASE REVIEW AND INITIAL

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.
If health insurance is not in your name, please provide the following information:

Name of insured _____ Insured's D.O.B. _____

Relationship to Patient _____

Insured's Employer (if applicable) _____

I hereby authorize Jennifer Waddell, H.I.S. and her associates to furnish information to my insurance carrier concerning my hearing and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE _____ DATE _____

DISCLAIMER: *As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. When we receive payment from your insurance company, we will reimburse you for the amount the insurance company covered/paid.* ***INITIAL:*** _____

PLEASE REVIEW AND INITIAL

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE.***

YES, please send a copy to my physician _____ NO, do not send a copy to my physician _____

Physician's Name _____ Phone _____

Office Address _____

MEDICAL HISTORY

Have you ever had ear surgery? NO ____ Left _____ Right _____ Both _____

Please describe _____

Do you have pain/discomfort in your ear? NO ____ Left _____ Right _____ Both _____

Do you have you any drainage in your ear? NO ____ Left _____ Right _____ Both _____

Do you have a history of ear infections? NO ____ Left _____ Right _____ Both _____

Do have ringing or other noises in your ear? NO ____ Left _____ Right _____ Both _____

Constant _____ OR Intermittent _____

Do you experience dizziness or vertigo? YES ____ NO _____

Do you have diabetes? YES ____ NO _____

Are you taking blood thinners? YES ____ NO _____

Have you been exposed to excessive noise? YES ____ NO _____

Please describe _____

Is there a family history of hearing loss? YES ____ NO _____ Who?_____

Have you had your hearing tested before? YES ____ NO _____ When?_____

What were the results? _____

Do you currently use a hearing aid? YES ____ NO _____ How long?_____

What type? _____ Does it meet your needs? _____

Have you seen your physician regarding any of the above? _____

Any other medical conditions we should be aware of? _____

_____

LISTENING SITUATIONS	How well do you hear in this situation?			How often are you in this situation?		
	POOR	FAIR	WELL	OFTEN	SOMETIMES	RARELY
Television						
Phone						
Restaurant						
Church						
Work						
Car						
Large Social Gathering						

OFFICE USE ONLY

Needs Hearing Aids: R _____ L ____ ORDER STOCK DEMOS

Brand _____ Name _____ Model _____

Receiver # _____ Power _____ Color _____

Accessory _____

Accessory _____

Notes _____

_____

_____