BETTER HEARING CARE, INC
3385 Burns Road, Suite 204
Palm Beach Gardens, Florida 33410
(561) 624-7525

Name: ____

Street Address ____

City_____________________________ **State**_______ **Zip** _______________________

Phone ______________________**Age** _________ **Birth Date** _____________________

Spouse: ____

Email address: ____

Please check: _________ **Permanent Resident** ___________ **Seasonal Resident**
Primary Care Physician's Name and Address:

____

____

We have your permission to contact your physician regarding your hearing health care

__________ **Yes** ____________ **No**

Referred by or heard of us from: ____

Will this be your first hearing test? ______**Yes** ______ **No**

Last test date ___________________

Have you seen a doctor in the past 6 months? ______ **Yes** ______ **No**

Have you ever had ear surgery? ______ **Yes** ______ **No**

Deformity of the ear? ______ **Yes** ______ **No**

Sudden or rapid hearing loss in the last 90 days? ______ **Yes** ______ **No**

Acute or recurring dizziness? ______ **Yes** ______ **No**

Are you experiencing any ear pain? ______ **Yes** ______ **No**

Has the hearing in one ear worsened in the last 90 days? ______ **Yes** ______ **No**

Have you ever found it necessary to have wax removed? ______ **Yes** ______ **No**

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Name : ____

In which ear is your hearing worse? _____ Left ______ Right ______ Same

Have you noticed that people mumble? ______ Yes ______ No

Do you find that you have to ask people to repeat themselves? ______ Yes ______ No

Do you sometimes hear words but don't always understand them? ______ Yes ______ No

Do you find it difficult to hear in noisy places? ______ Yes ______ No

Have you ever been told that you speak loudly? ______ Yes ______ No

Do others complain that you set the TV too loud? ______ Yes ______ No

Do you avoid social events because of your hearing difficulty? ______ Yes ______ No

Do you find it difficult to understand speech when your back is to the speaker?

______Yes ______ No

How many years have you experienced hearing difficulty? _________________________

Do you have a hearing aid? ______ Yes ______ No

If yes, the brand name? _________________________ How old_________________________

Do you have a pacemaker? __________Yes __________No

Do you have health insurance? ____________ Yes _____________ No

If yes, please provide us with your insurance cards so we can make copies for your file.

MEDICAL WAIVER

I have been advised by my hearing care professional that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing aid. The use of a hearing aid cannot restore hearing to normal. Improvement is based on duration and severity of impairment. Hearing aids cannot distinguish between speech and undesirable noise. I am at least 18 years of age.

Signature ______________________________________ Date ____________________________________