SUMMIT HEARING AID CENTER
75 Summit Avenue , Summit, NJ 07901, 908-277-6886

PATIENT INFORMATION

Date: _____/_____/_____ **Referred By:** _____

Name:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone: Home: (_____**)**_____-_____ **Work: (**____**)**_____-_____

Cell: (_____**)**_____-_____ **Preference (Circle one): Home Work Cell**

E-mail: _____

Occupation _____ **Birth date:** _____/_____/_____

Primary Insurance_____ **ID#** _____

Primary Physician:_____**City:**_____ **Tel #**_____

HEARING HEALTH HISTORY

Have you ever had ear surgery?	Yes	No
Have you noticed a sudden change in your hearing?	Yes	No
Do you have any pain or discomfort in your ears?	Yes	No
Have you experienced any dizziness?	Yes	No
Do you experience ringing or buzzing?	Yes	No
Do your ears feel blocked or full?	Yes	No
Do you have a history of ear infections?	Yes	No
Are you sensitive to loud sounds?	Yes	No
Have/had any family members have difficulty with their hearing?	Yes	No
Have you had any accidents/head injuries?	Yes	No

If *yes*, please describe

_____

_____

List current medications including prescription, over-the-counter, and vitamins or supplements:
***If you have a list of your medications we will make a copy of it ***

Drug Name (Brand Name or Generic Name)	Dosage	Frequency (How Often)	Method (Oral Pill, Drops, Nasal Spray, Injection, etc.)

Please turn over the page to complete and sign form ➔

COMMUNICATION DIFFICULTIES

Which ear do you use on the phone	Left	Right
Do you have trouble hearing on the phone?	Yes	No
Do you ask others to repeat?	Yes	No
Do you avoid social situations?	Yes	No
Do you hear but have trouble understanding words?	Yes	No
Do you play the television loudly?	Yes	No
Do you have trouble understanding in background noise?	Yes	No

Please list activities limited/stopped due to hearing difficulties: _____

_____

_____

Do you wear a hearing aid? _____

Manufacturer _____ Model _____

Right Serial #_____ Left Serial # _____

I understand and agree that, (regardless of my Insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes of the above information.

Signature_____Date_____