

Date of Call: _____

Office: _____	Served By: _____	
Day: _____	Time: _____	Date: _____

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Alternate Phone: _____

Work/Cell Telephone: _____ Alternate Phone: _____

Who will be Accompanying You?: _____ Relationship?: _____

HOW DID YOU HEAR ABOUT US?

Newspaper Website/Internet Friend/Family Referred (Name) _____
 Television Ad Senior Living Doctor Referral (Name) _____
 Phone Book Received a Letter Other (Please explain) _____

ADDITIONAL INFORMATION

Seasonal Address: _____ City: _____ State: _____ Zip: _____

(Occasionally we send out important news/information to our patients. Please include your email-address below:)

E-Mail Address: _____

PHYSICIAN INFORMATION

Name of Family Physician or ENT: _____

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

HEARING HEALTH HISTORY

	Yes	No	If Yes, Please List/Describe:
Do you ever notice its difficult to understand words clearly?			
Do you have trouble hearing women/children?			
Do people say you have the TV or radio turned up?			
Do you ask people to repeat themselves?			
Do you sometimes feel that people are talking "softly" or mumble?			
Do you have difficulty hearing speech in background noise?			
On a scale from 1-10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability? (circle one) 1 2 3 4 5 6 7 8 9 10			

AUTHORIZATIONS

Authorization to Release Information: I hereby authorize the release of information contained in my medical record & other related information, verbal and written, to be shared with my physician or other hearing health care professionals regarding my testing, evaluation, treatment, processing of a claim or to receive authorizations from any insurance or government agency as it relates to my treatment plan.

Trial Period: Woodard Hearing Centers offers a 60-day trial period upon which time a full refund will be honored less the professional services fee and any custom ear mold charges.

Responsibility for Payment: I understand that I am personally responsible for payment which is due at the time of delivery.

Signature: _____ Date: _____

TO BE COMPLETED BY AUDIOLOGIST/DISPENSER

Accompanied by: _____ Relationship to Patient: _____

Tested Before? _____ When? _____ Where? _____ Findings: _____

Possible Cause of Hearing Loss? _____

Past Medical Treatment/Surgery on ear/s? _____ When? _____ Where? _____

Previous User: Yes/No	R	Mfgr:	Model:	Serial #	Aid Type:	Battery:	Yr. Purch:	Purchased From:
How Long? _____	L	Mfgr:	Model:	Serial #	Aid Type:	Battery:	Yr. Purch:	Purchased From:

Comments: _____