PATIENT QUESTIONAIRE

Name: _____Today's Date: _____

Address: _____City: _____Zip: _____

Phone: _____Cell _____ Email_____

Birth Date: _____ Primary Care Physician: _____

Health Insurance or HMO: _____ Do you have benefits for hearing aids? _____

How did you learn about us: Friend/Relative: _____Physician: _____

Internet: _____Yellow Page: _____ Other: _____

PLEASE CIRCLE YOUR ANSWER

- Do you think you have a hearing loss? ……. Yes or No
- Are you having difficulty hearing in …….. Both Ears……. Left Ear……. Right Ear
- Was the onset of your hearing loss …… Gradual……or……Sudden
- Have you ever worked in a noisy environment or been exposed to excessive noise?.....Yes or No
  If Yes, please describe _____
- Have you had your hearing tested before? ……Yes or No
- Do you have any ringing or buzzing noises (tinnitus) in either ear? ……Yes or No
- Do you experience dizziness, ear pain, itchy ears, or fullness/pressure in either ear? ……Yes or No
- Have you ever had ear surgery?.....Yes or No
- Have you ever had an ear infection?.....Yes or No
- Have you been fitted with a pacemaker?.....Yes or No

I authorize Higgins Hearing and Audiology to release information requested with regard to processing my claims.

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 on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Higgins Hearing of any changes in my health status or in the above information.

All new hearing aids have a 30-day trial period, with refund for the instruments only, minus a $125.00 restocking fee per hearing instrument. Warranties on hearing aids are issued by the manufacturer.

X _____ _____

Signature of Patient (or Personal Representative) Date