

Calvert Hearing Care

2301 Olympia Drive, Suite 300
Flower Mound, TX 75028
Phone: 972-539-7821
Fax: 972-539-7849

PATIENT INFORMATION

Patient Name: _____ DOB ____ / ____ / ____ Age ____
Guardian Name (if Minor): _____ E-Mail: _____
Address: _____ Home Phone: _____
City/State: _____ Zip: _____ Cell Phone: _____
Employer: _____ Work Phone: _____
How did you hear about our office: _____ Referred by: _____

PHYSICIAN INFORMATION

Family Physician: _____ Office Phone: _____
Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Insurance Company: _____ Primary Insured Name: _____
Primary Relationship to Patient: Parent Guardian Spouse Self (please complete information below)
Primary Insured ID#: _____ Group # _____ Sex: Male Female DOB ____ / ____ / ____
Primary Insured Employer: _____ Marital Status: Single Married
Does patient have Medicare or Medicaid coverage? Yes No

I hereby request that the licensed clinicians at Calvert Hearing Care provide me with audiological evaluations and services. I authorize the confidential release of this information to any industry related entity in order to provide necessary services. I understand that all my personal and audiological information will be kept confidential as required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

I accept the private practices of Calvert Hearing Care, and a copy will be available at my request.

I authorize release of any information necessary to process an insurance claim if applicable.

PATIENT'S SIGNATURE

DATE

MEDICAL HISTORY

Please Circle

- 1) Has a doctor examined you in the past 6 months?Yes No
- 2) List all medications you are taking. _____
- 3) Do you have : Heart Problems Diabetes Epilepsy
- 4) Will this be your first hearing test? Yes No
- 5) Have you ever had ear surgery? Yes No
- 6) Do you have any deformity of the ear? Yes No
- 7) Have you had sudden or rapid hearing loss in the last 90 days? Yes No
- 8) Do you have acute or recurring dizziness? Yes No
- 9) Has your hearing in one ear worsened in the past 90 days? Yes No
- 10) Do you ever have ear pain? Yes No
- 11) Have you ever had wax removed from your ears by a doctor? Yes No
- 12) In which ear is your hearing the worst? Left Right Both
- 13) Do you have: Ringing Roaring Buzzing if so: Left Right Both
- 14) Noise exposure: Occupational Recreational Military
- 15) Family history of hearing loss: Yes No

HEARING HISTORY

- 1) Do people seem to mumble? Yes No
- 2) Do you find yourself asking people to repeat what they have said? Yes No
- 3) Do you sometimes hear words but do not always understand them? Yes No
- 4) Do you find it difficult to hear in noisy places? Yes No
- 5) Have you been told that you speak loud? Yes No
- 6) Is it difficult to understand speech when your back is to the speaker? Yes No
- 7) Do others complain that you play the TV too loud? Yes No
- 8) Have you occasionally missed the ringing of a telephone? Yes No
- 9) Do you find it difficult to hear when using a telephone? Yes No
- 10) Do you avoid social events because of hearing difficulty? Yes No
- 11) How many years have you experienced hearing difficulty? _____
- 12) How did your hearing loss develop? Suddenly or Gradually
- 13) Do you know the cause of your hearing loss? Yes No
- 14) Do you have a hearing instrument? Yes No
- 15) If a hearing loss is discovered, are you ready for help? Yes No

**HEARING DEVICE USER
(While wearing hearing devices)**

- 1) Do you hear but have difficulty understanding? Yes No
- 2) Do you have difficulty understanding when two or more people are talking? Yes No
- 3) Do you have difficulty understanding when in a crowd? Yes No
- 4) Do you have difficulty understanding at a distance? Yes No
- 5) Do you have difficulty knowing from which direction sounds are coming? Yes No
- 6) Do you have difficulty while using a telephone? Yes No
- 7) Does your own voice sound hollow and unnatural? Yes No
- 8) Do words often run together? Yes No
- 9) Do your hearing instrument(s) make sounds loud enough? Yes No
- 10) Are some sounds too loud? Yes No
- 11) Do your hearing device(s) make sounds tinny? Yes No
- 12) Do your hearing device(s) whistle? Yes No
- 13) Do your hearing devices(s) make your ears sore? Yes No

PATIENT HISTORY:
