Calvert Hearing Care

109 N. Central Expressway, Suite 533
Allen, TX 75013
Phone: 972-359-7800
Fax: 972-359-7963

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:

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