Miracle-Ear®

Confidential Record Form

Name: _____ **Date:** _____
First Last Initial

☐ **Married** ☐ **Single** ☐ **Widow(er) Companion:** _____
Name Relationship

Birthdate: ___/___/___ **Age:**____ ☐**Male** ☐**Female**

Permanent Address: _____
Street City State Zip

Seasonal Address: _____
(If available) Street City State Zip

Phone:(Home) _____ (Cell) _____ **Work:** _____

Email Address: _____ **How many children do you have?** _____

Occupation: _____

If retired, what was your occupation? _____

Family Contact: _____ **Phone:**_____
(Not living with you) Name Relationship

Family Physician Name: _____

Family Physician Address: _____
Street City State Zip

Would you like a copy of your test sent to your doctor? □Yes □No

Primary Insurance Provider: _____

Referral Source (Check One):

□ Doctor Referral □Patient Referral □ Friend/Family □ Television □ Mail
□ Yellow Pages □ Store Sign □ Newspaper □ Walk-In □ Other: _____

Do you have any allergies? □ No □Yes Please List: _____

Do you have arthritis? □ No □ Yes **Are you diabetic?** □No □ Yes

Are you taking medications? □ No □Yes Please list: _____

Have you received medical or surgical treatment for a hearing loss? □ No □ Yes

If yes, when? _____ Physician/ENT: _____ Phone: _____
Address:

_____