Hear Again 2/Mountain Hearing Center **Date**:_____
Confidential Patient Case History

**Client Name**: Mr./Mrs./Miss/Ms./Dr. _____
First Last

**I would like to be addressed as**:_____

**Address**:_____
Street Address City Zip Code

**Home Phone**:_____**Work Phone**:_____**Cell Phone**:_____

**Preferred contact phone number**:_____

**Email Address**:_____

**Date of Birth**:_____ **Occupation**:_____

**How did you hear about us?**:_____

**MEDICAL/ INSURANCE (Please be ready to have insurance cards copied)**

**Primary Care Physician**:_____**Specialty**:_____

**Address**:_____ **Phone**:_____

**Do you have medical coverage for hearing aids? Yes_____ No_____ Not Sure_____**

**Name of Primary Insurance Company**:_____

**Subscriber's Name:**_____ **Subscriber's Date of Birth:**_____

**Name of Secondary Insurance Company**:_____

**HEARING HISTORY**

**Have you ever had ear surgery? Yes____ No_____ Which ear**?_____

**For what reason**?_____

**Do you believe you have hearing loss? Yes___ No___ Not sure___ Which ear? Right____ Left____**

**Has your hearing been tested before? Yes___ No___ By Whom?**_____

**Do you currently wear hearing instruments? Yes___ No___ What ear: Right_____ Left_____**

**Do the hearing instruments help you? Yes_____ No_____ Do you like them? Yes____ No_____**

**Have you seen a neurologist or a neuropsychologist? Yes_____ No_____**

**If so, for what conditions?_____**

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**Are you motivated to try hearing instruments? Yes_____ No_____**

**Please make an "X" on the line that best describes your readiness:**

**Ready and Willing_____ Ready but with questions_____ Not Ready At All_____**

**Who is encouraging you to try Hearing Instruments? Me_____ Family_____ Friend_____**

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**I understand that I am fully responsible for any charges incurred by the provider's evaluation and treatment even though I am covered by health insurance. I also understand that the provider will process insurance claims if possible and appropriate. I assign all medical payments for my care and treatment to Dr. Eleanor Wilson, Audiologist at Hear Again 2/Mountain Hearing Center.**

**Client Signature:_____ Date:_____**

**Parent/Caregiver Signature:_____ Date:_____**

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**MEDICARE CLIENTS: I understand that services provided by this office may not be reimbursed by Medicare. Charges have been fully explained to me prior to the services provided.**

**Client Signature:_____ Date:_____**

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**I authorize the provider, Dr. Eleanor Wilson, Audiologist, to release information to my primary care physician or referring physician. I also authorize her to release any information to process any insurance claims.**

**Client Signature:_____ Date:_____**