HEAR BETTER NOW
Tinnitus & Hearing Center

PATIENT INFORMATION

Name: _____ Date of Birth:_____

Gender: _____ Age: _____ Marital Status: ☐ Married ☐ Single ☐ Widowed

Name of Spouse: (if applies) _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Your reason for today's visit? _____

_____

Insurance: ☐ Medicare ☐ Medicaid ☐ Other Name of Insurance: _____

PLEASE GIVE ALL INSURANCE CARD(S) AND MEDICATION LISTS TO THE SECRETARY FOR COPYING

MEDICAL HISTORY

Name of Primary Physician:_____

Clinic Name: _____ Clinic Telephone: _____

Clinic Address: _____

Have you seen a doctor specializing in diseases of the ear? ☐ Yes ☐ No

Do you take a blood thinner? ☐ Yes ☐ No

Have you ever had any type of ear surgery? ☐ Yes ☐ No

When?_____ By Whom?_____ What type of surgery?_____

Do you have any noises or sounds in your ears? _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, I have received a copy of the Privacy Practices of Hear Better Now LLC. I am aware that this notice describes the obligations regarding, and permitted uses of, medical information about me by Hear Better Now LLC., as well as my rights regarding this information and its use.

Signed:_____ Date: _____

Consent to Telephone Contact

As a potential consumer, I hereby consent and agree to receive telephone calls made by or on behalf of Hear Better Now LLC. Calls can be made only to the telephone number(s) listed below. I acknowledge that this statement continues my express permission to or entities calling on its behalf, to place calls to me for business purposes. This permission shall remain in effect as long as I have not asked to be placed on HBN's company specific "Do-Not-Call" list. NOTHING IN THIS CONSENT FORM OBLIGATES ME TO MAKE ANY PURCHASES OR OTHERWISE RESPOND TO CALLS FROM HEAR BETTER NOW LLC.

Date: _____

Signed: _____

Telephone Number(s): _____

Eugene P. Antonell
Board Certified Hearing Instrument Specialist
MA Lic. #80 / RI HAD #00242
Owner/President

*******PLEASE COMPLETE FOR HEARING PROBLEMS ONLY*******

1. What is your hearing aid experience?

- ☐ I have a hearing device and use it regularly on the ___ right ear ___ left ear.
- ☐ I have a hearing device, but don't use it, or use it only occasionally?
- ☐ I tried a hearing device, but returned it.
- ☐ I have inquired about hearing devices at another office, but did not purchase at that time.
- ☐ I have never used a hearing device.

2. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device. (1=Most Important, 2=Important, 3=Somewhat Important, 4=Least Important) Please use each number only once.

___Sound Quality & Clarity ___Durability/Reliability ___Cost ___Appearance

3. What motivated you to come into the office today?_____

_____

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated 1 2 3 4 5 6 7 8 9 10 Very Motivated

Listening Situation	How well do you hear in this situation?			How often are you in this situation?		
	POOR	FAIR	GOOD	OFTEN	SOMETIMES	RARELY
Television	☐	☐	☐	☐	☐	☐
Music	☐	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐	☐
Church	☐	☐	☐	☐	☐	☐
Meetings/Lectures	☐	☐	☐	☐	☐	☐
Work Place	☐	☐	☐	☐	☐	☐
Telephone Conversation	☐	☐	☐	☐	☐	☐
Car	☐	☐	☐	☐	☐	☐
Large Social Gathering	☐	☐	☐	☐	☐	☐
Quiet Room (1 to 2 People)	☐	☐	☐	☐	☐	☐

----------STOP:RETURN TO SPECIALIST----------

FDA Regulations

- ☐ Yes ☐ No (i) Visible congenital or traumatic deformity of the ear?
- ☐ Yes ☐ No (ii) History of active drainage from the ear within the previous 90 days?
- ☐ Yes ☐ No (iii) History of sudden or rapidly progressive hearing loss within the previous 90 days?
- ☐ Yes ☐ No (iv) Acute or chronic dizziness?
- ☐ Yes ☐ No (v) Unilateral hearing loss of sudden or recent onset within the previous 90 days?
- ☐ Yes ☐ No (vi) Audiometric air-bone gap equal to or greater than 15 decibels at 500 HZ, 1,000 HZ, and 2,000 HZ?
- ☐ Yes ☐ No (vii) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?
- ☐ Yes ☐ No (viii) Pain or discomfort in the ear?