Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age\_\_\_\_\_ Male Female

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

SSN: XXX-XX-\_\_\_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Primary Care Physician (Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Date last seen by Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: Phone Call Text Email

**Emergency Contact**:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Contact (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can records be released to this person? Yes No

**How did you hear about us?** Please check all that apply and provide name(s) where applicable.

\_\_\_ Physician Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Newspaper \_\_\_ Mail \_\_\_Website \_\_\_Facebook \_\_\_\_ TV \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:**

Name of Business \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HR Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Retired

**Please Initial all 3 places and Sign and Date at the bottom:**

\_\_\_\_\_\_\_\_ **Consent to Treatment**: I agree to the audiological services necessary for care and treatment provided under the general and special instructions of the audiologist.

\_\_\_\_\_\_\_\_ **Privacy Practices**: Privacy Practices have been reviewed and made available to me. I understand that Cornerstone Audiology may send me educational information on the products and services offered.

\_\_\_\_\_\_\_\_ **Release of Information**: I, the undersigned, hereby authorize Cornerstone Audiology to release my records to the physician(s) listed above and provide/request updated medical records needed to aid in my evaluation and treatment.

\*\*Responsible Party Signature (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| HEARING HISTORY: | YES  | NO |
| Is this your first hearing test? |  |  |
| Have you ever had ear surgery? |  |  |
| Do you have any pain in your ears? |  |  |
| Do you have a history of ear infections? |  |  |
| Do you have a family history of hearing loss? |  |  |
| Do you have a history of noise exposure? |  |  |
| Do you have noises in your ears? (i.e. ringing, roaring) |  |  |
| If so, is it bothersome? |  |  |
| Have you taken medication that may have affected your hearing? |  |  |
| Have you noticed dizziness? |  |  |
| Do you think you have a hearing loss? |  |  |
| Do you have concerns with memory loss? |  |  |
| Do you have issues with dexterity? (fine motor skills in hands) |  |  |
| HEARING AID HISTORY: |  |  |
| Have you tried hearing aids before? |  |  |
| Are you currently a hearing aid user? |  |  |
| Were you satisfied with your hearing aids? |  |  |

|  |
| --- |
| MEDICAL HISTORY: Please check all that apply\_\_\_Heart \_\_\_Current use of blood thinner \_\_\_Pace Maker\_\_\_Allergies \_\_\_Cancer \_\_\_Diabetes Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Do you have difficulty hearing on your cell phone? YES NO Make/Model of cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you know any patients of Cornerstone Audiology? YES NOIf yes, who do you know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list situations in which you would like to hear and/or understand better: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was there any specific event or circumstance that brought you in today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is there anything else we should know?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  |  NO  |  SOMETIMES | YES |
| Does a hearing problem cause you to feel embarrassed when you meet new people? |  |  |  |
| Does a hearing problem cause you to feel frustrated when talking to members of your family? |  |  |  |
| Do you have difficulty hearing/understanding co-workers, clients or customers? |  |  |  |
| Do you feel handicapped by a hearing problem? |  |  |  |
| Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? |  |  |  |
| Does a hearing problem cause you difficulty in the movies or in the theatre? |  |  |  |
| Does a hearing problem cause you difficulty when listening to TV or radio? |  |  |  |
| Do you feel that your hearing problem limits or hampers your personal or social life? |  |  |  |
| Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? |  |  |  |

If we find your hearing challenges could be helped by hearing devices, would you be open to trying a solution? YES POSSIBLY NOPlease check hearing aid features you may be interested in:  \_\_\_\_Invisibility \_\_\_\_Maintenance-Free \_\_\_\_Bluetooth/Smart Phone Streaming  \_\_\_\_Rechargeability \_\_\_\_Cost-Effective \_\_\_\_Hearing in Noise  |