ActiveHearing & Audiology
2680 N. Snelling Ave. Suite #265
Roseville, MN 55113
651-600-3245

Chart # _____ Date _____

Patient Name _____ DOB ___/___/___
First MI Last M D Y

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _____
First MI Last

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Sex M F

E-Mail _____

Mailing Address _____
Street City State Zip

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

☐ Mail ☐ Newspaper Ad ☐ Promotional Call ☐ Radio ☐ Insurance

☐ Yellow Pages ☐ Sponsored Event ☐ Health/Senior Fair ☐ Website ☐ Employer

☐ Referred by Friend _____

☐ Referred by Physician _____

☐ Other _____

Reason for Appointment _____

Medical/Hearing History

Do you have any allergies? ..... ☐ Yes ☐ No

If yes, please list _____

_____

Do you have a cardiac pacemaker or other electronic implant? ..... ☐ Yes ☐ No

Do you have arthritis? ..... ☐ Yes ☐ No

Do you have diabetes? ..... ☐ Yes ☐ No

Are you currently taking medication? ..... ☐ Yes ☐ No

If yes, please list _____

Are any of these medications blood thinners? ..... ☐ Yes ☐ No

Do you experience ringing in your ears? ..... ☐ Yes ☐ No

When did you first notice that you were having difficulty with your hearing? _____

In which ear do you have greater difficulty hearing? ..... ☐ Right ☐ Left ☐ Same

What do you believe caused your hearing loss? _____

Have you ever had a hearing evaluation? ..... ☐ Yes ☐ No

If so, when and where was your most recent exam? _____

_____

Was anything recommended as a result of this evaluation? _____

_____

Have you received any medical or surgical treatment for a hearing loss? ..... ☐ Yes ☐ No

If yes, when?_____ Physician/ENT:_____ Telephone:_____

Street Address: _____ City: _____ State: _____ ZIP: _____

Additional information about treatment: _____

_____

Amplification History

Have you worn hearing aids in the past? ☐ Yes ☐ No Type: _____

Do you currently wear hearing aids? ☐ Yes ☐ No Type: _____

If yes, and you could improve 2-3 things about your current hearing instrument, what would they be? _____

_____

_____

_____

*************PLEASE READ CAREFULLY AND SIGN BELOW*************

- I give permission to Active Hearing & Audiology to release information, verbal and written contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

  _____ Initial to refuse permission to release records

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Active Hearing & Audiology permission to treat my concerns.

I have read and understand all the above information.

_____ _____

A copy of this signature is as valid as the original — Date

Signature of Parent or Guardian _____

Hearing Care Professional Use Only

FDA Questions

* Visible congenital or traumatic deformity of the ear?	☐ Yes	☐ No
* Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?.....	☐ Yes	☐ No
* Any history of, or active drainage from, the ear within the previous 90 days?	☐ Yes	☐ No
* Any history of sudden or rapidly progressive hearing loss within the previous 90 days?	☐ Yes	☐ No
* Have you experienced any acute or chronic dizziness?.....	☐ Yes	☐ No
* Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days?.....	☐ Yes	☐ No
* Have you experienced any pain or discomfort?	☐ Yes	☐ No
* Audiometric air-bone gap equal to, or greater than, 15 dB at 500 Hz, 1000 Hz, and 2000 Hz?..	Yes	No

*** If answer is "Yes" to any of these questions, customer must be referred to a physician or ear specialist prior to a hearing instrument fitting.**

Representative _____ License _____
Number