201 Montauk Highway · Suite 4
West Hampton Beach, NY 11978
631-878-1992

34 Main Street
Vergennes, VT 05491
802-870-7170

PATIENT INTERVIEW FORM

Patient Name: ______________________ Date: ____________

1. Please describe the problem you are currently experiencing with your hearing:
____
____
____

2. How long have you been experiencing these difficulties? ______________________

3. Do these problems occur when you are:
   A. In a quiet environment ________ In a noisy environment ________
   B. In a one-on-one conversation ________ In a group conversation ________
   C. On the telephone ________
   D. Watching television ________

4. Does this problem affect one ear or both ears? ________

5. Is the decline in your hearing a gradual loss ________ or sudden loss ________

6. Is there any family history of hearing loss? ________

7. Is there any history of hearing aid use? ________

   If yes, please describe:
   ____
   ____
   ____

8. Are you experiencing tinnitus (ringing in the ears)? ________.

   IF YES:
   A. Is it affecting one ear or both ears? ____________________
   B. What is the frequency & duration? ____________________
   C. How long have you been experiencing it? ____________________
   D. Has there been a change in the intensity of the tinnitus? ____________________

9. Do you experience dizziness? ____

10. Do you experience frequent headaches? ______________________________________

11. Any history of head trauma? ____

12. Any history of ear surgery? ____

13. Describe any chronic health related issues you currently have (hypertension, diabetes, etc.):
    ____
    ____

14. Please list any medications you are currently taking: ____________________________
    ____
    ____

15. Any history of noise exposure (job or recreational): ____________________________
    ____

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PATIENT INFORMATION FORM

Today's Date: ___________________

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, MI)	Date of Birth	Sex	Marital Status
Address	City	State	Zip

PLEASE CHECK THE BEST FORM OF CONTACT:		
☐ Email Address:	☐ Home Phone:	☐ Cell Phone:

EMERGENCY CONTACT:		
Name:	Relationship to You:	Contact's Phone:

PRIMARY CARE PHYSICIAN:		
Name:	PCP Phone:	Referred By:

INSURANCE INFORMATION

Primary Insurance Name	ID #	Group #
Name of Insured	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other *If relationship is other than self, please complete the section below*	
Dependent's Date of Birth	Dependent's Address	

Secondary Insurance Name	ID #	Group #
Name of Insured	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other *If relationship is other than self, please complete the section below*	
Dependent's Date of Birth	Dependent's Address	

Home Audiology Services, P.C.

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PATIENT SIGN-OFF FORM

I have read and understand the following documents:
(please check)

- ○ HIPAA
- ○ Release of Information
- ○ Signature on File
- ○ Patient Information & Office Policies

Name of Insured: Last ______________________________, First ____________________

Name of Patient: Last ______________________________, First ____________________

Patient's Relationship to Insured: ____

_____________________________________ ____________

Signature of Patient Date

_____________________________________ ____________

Printed Name Date