Home Audiology Services, P.C.

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	

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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