KIRSCH

PATIENT INTAKE FORM

Patient Name: Mr/MRS/DR/MS_____
(LAST) (First) (MI)

Birth Date:_____ Age:_____ Sex: M____ F_____

Home Address: _____ City_____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Cellular/Alt: _____

Social Security (Insurance Purposes Only):_____

Occupation: _____ **Referred by:** _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse:_____ Phone:_____

Family Physician: _____Phone:_____

Please answer the following questions to help us serve you better:

Chief Complaint (Circle all that apply): Hearing Loss (right/left ear) / Ringing in Ears / Difficulty hearing in certain situations (in quiet /in noise)

Have you had your hearing tested before? If yes, when: _____

Do you hear ringing or noises in your ears?_____ _____

Have you had recent earaches, ear infections, ear discharge?_____

Is there a history of Hearing Loss in your family? If yes, explain:_____ _____

Do you have dizzy spells or nausea?_____ _____

When did you first notice your hearing loss?_____

Have you seen another doctor regarding your hearing loss? If yes, who

_____

Have you been exposed to high noise levels?_____

Do you feel your hearing has gradually gotten worse or suddenly?_____

Have you ever had surgery that affected your hearing? _____

Do you currently use hearing aids? If yes, how long: _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the provider and I am financially responsible for non-covered services. I also authorize the provider to release any information acquired through the course of my examination or treatment to other healthcare providers, insurance companies or educational facilities. I hereby acknowledge that I have received a copy of Kirsch Audiology's Notice of Privacy Practices.

Patient Name (Print): _____ Date: _____

Patient Signature: _____