HSC
Hearing Solution Center

Patient Information

135 S Sharon Amity Road, Ste 208, Charlotte, NC 28211 · P: 704.944.4283

Patient Name: _____ Gender: M ☐ F ☐ Date: _____
(Last) (Middle) (First)

Preferred Name: _____ D.O.B.: ___ / ___ / ___ SS#: ___ - ___ - ___

Marital Status: Married ☐ Single ☐ Widowed ☐ Spouse Name: _____

Cell Phone: _____ Home Phone: _____

Occupation: Prior ☐ Current ☐ _____ Work Phone: _____ EXT: _____

Email: _____

Preferred Method of Contact: ☐ Cell ☐ Home ☐ Email

Mailing Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us?

- ☐ Mail
- ☐ Employer
- ☐ Health/Senior Center
- ☐ Google Search
- ☐ Call
- ☐ Referred by Friend: _____
- ☐ Newspaper Ad
- ☐ Website
- ☐ Referred by Physician: _____
- ☐ Sponsored Event
- ☐ Insurance
- ☐ Other: _____

Insurance Information

Please give your insurance card(s) to our front office staff so we can make a copy for our records

Do you have Insurance? **Yes / No** D.O.B. of Policy Holder: ___ / ___ / ___

Insurance Company Name: _____

Name of Policy Holder: _____ Relation to Policy Holder: _____

Policy Number: _____ Group Number: _____

Secondary Insurance

Insurance Company Name: _____

Name of Policy Holder: _____ Relation to Policy Holder: _____

Policy Number: _____ Group Number: _____

What is the primary reason for today's visit:

Are you experiencing problems with your hearing? **Yes / No**

Which ear? **Both / Right / Left**

Has the hearing loss been: **Gradual / Sudden / Fluctuating**

How long have you noticed problems with your hearing?

Recently / 1-3yrs / 4-6yrs / 7-10yrs / More than 10 Years

What do you think may have caused this?

Have you had your hearing tested before? **Yes / No**

If yes, when: _____

What was the outcome of your previous hearing test?

No loss / Mild loss / Hearing aids recommended

Do you currently use a hearing aid(s)? **Yes / No**

Have you ever used a hearing aid(s)? **Yes / No**

Do any members of your family have a hearing problem? **Yes / No**

Do you have a history of ear infections? **Yes / No**

Have you had any of the following in the last six months?

(Circle all that apply) **Medically diagnosed ear pathology / Ear pain**
Pressure or fullness in the ears / Ear drainage

Have you had surgery on your ears? **Yes / No**

If Yes, Which ear? **Both / Right / Left**

Do you hear noises in your ears or head? (Tinnitus) **Yes / No**

Which ear? **Both / Right / Left**

If Yes, how often do you hear these noises?

Constantly / Frequently / Occasionally / Very Seldom

How would you describe the noise?

Ringing / Buzzing / Roaring / Screeching / Crickets / Pulsating

Are you experiencing any problems with dizziness? **Yes / No**

If Yes, is your dizziness accompanied by the following? (Circle all that apply)

Nausea / Vomiting / Noises in your ears / Loss of Consciousness

Do you take medications regularly? (Please list in space below) **Yes / No**

Allergies to medication or plastics? _____

Have you ever been exposed to excessively loud noises? **Yes / No**

Are you currently employed? **Yes / No / Retired**

What is or was your occupation? _____

Do you have or have you had any of the following? (Circle all that apply)

Sinuses/Allergy
Mumps
Thyroid Problems
Stroke
High Blood Pressure
Cancer
High Cholesterol
Headaches
High Fevers
Vascular Problems
Renal Disease
Kidney Problems
Tinnitus
Dizziness/Vertigo
Recent Change of Hearing
Family History of Hearing Loss
Meningitis
Measles
Diabetes
Heart Attack
Arthritis
Blood Disorder
Genetic Disorders
Heart Problems
Scarlet Fever
Noise Exposure
Alzheimer's
Stroke
Pain in Ears

Other:

If **Cancer** was circled: How long ago?

Type of treatment?

If **Head Injury** was circled: When?

If **Noise Exposure** was circled: When?

If **Recent Change of Hearing** was circled: When?

Which Ear? **Both / Right / Left**

Please List Current Medications Here:

Patient Agreement

- ☐ I give permission to my hearing healthcare professional to release information–verbal and written, contained in my medical records and other documents–to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.
- ☐ I acknowledge that I agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.
- ☐ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

Signature _____ Date _____

Signature _____ Date _____

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR