1925 Grand Ave, Ste.,139, Billings, MT 59106
(406) 840-HEAR (4327)

Patient Name: (First)________________________(M.I.)_________(Last)____________________
Date of Birth______________________Age_____Male_____Female____ SSN____-___-______
Spouse's Name__________ If Child – Mother's or Father's Name_________________________
Street Address___________________________City_____________State______Zip_________
Mailing Address_________________________City_____________State______Zip_________
Home Phone #______________Work Phone#______________Cell Phone #________________
Email Address____
Employer_________________________________Occupation___________________________
Contact Person Not Living With
You______________________________Relationship_________
Address_________________City____________State____Zip_________Phone # ___________
Primary Care Physician ___________________ Clinic Name______________________________
Address______________________________ Phone #___________________________
Referred To This Office By____
Reason For This Visit?____
Which of the following do you have? Medicare____BC/BS____Other Insurance ______________
Private Pay____________ Medicaid_______
Subscribers Name___________________________________ID # ________________________
Policy # ________________________ Other Insurance__________________________________

Fee and Payment Policy:
If you have Audiology or hearing aid insurance benefits, we will be more than happy to bill your insurance for reimbursement directly to you, however we ask that you pay your bill half at time of sale and the second half at the time of receiving your hearing instruments. If your insurance company requires a referral from you primary care physician or prior authorization, you will need this in writing prior to your visit here. We accept payment by cash, check, Visa or Mastercard. If you have any questions regarding insurance benefits, Medicare benefits, insurance plans that require co-pay, please contact our office for assistance. We will be happy to help you.

I have read, I understand, and I agree to this Fee and Payment Policy.

X____
Signature of Patient or Responsible Party (Parent, Guardian, Trustee) Date

HEARING HISTORY:

Prior hearing test? (Y / N) When? ___________ Where?____________________________

Has your hearing worsened suddenly or gradually?_______________________________

Describe:____

____

____

When did you first notice that you had trouble hearing? Months______ Years ________

Which do you think is the better ear? Right___ Left___ No Difference_____

What do you think caused your hearing loss?____

Is there a history of hearing loss in your family? No___Yes____

Describe____

CLINICAL HISTORY:

Do you have ringing or other noise in your ears? No___Yes___

Right Ear Only______ Left Ear Only_______ Both Ears________

Rate loudness of ringing from 1 (soft) to 10 (loud) ________________

Is the noise louder in your left ear / right ear / or equal loudness? (please circle)

Is the noise constant / intermittent? (please circle)

When did the noise begin?________________________________

Have you ever had?	Wax cleaned from your ears?___	When?___________
	Ear infection? ___	When ?___________
	Ear surgery?____	When ? ___________
Do you currently have?	Earache or ear pain? ____	Ear congestion?_______
	Ear drainage?____	Severe dizziness?______

Do you have any serious health problems? ____

Describe____

____

NOISE HISTORY: Have you been exposed to loud noise?

Work___________ Hobbies__________ Recreation____________Military Service_____________

AMPLIFICATION HISTORY: Have you ever used a hearing aid?

No / Yes (please circle) Right Ear / Left Ear / Both Ears?

How Many Years Used?_________________ How Many Sets Purchased?_______________

If you currently wear a hearing aid(s) or if you have worn a hearing aid in the past, please describe your experiences, both positive and negative.

Positive:____

____

Negative:____

____

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Thank you very much for your time and effort in completing this history form.