OHIO HEARING INSTITUTE

PATIENT INFORMATION FORM

Date:_____

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail Address:_____

Occupation: _____

Emergency contact person: _____ Phone: _____

How did you hear about us:

☐ Mail ☐ Print Advertisement ☐ Website

☐ Referred by a Friend:_____
(Friend's Name)

Hearing Health Screening Form

Patient Name: _____ DOB: _____

Primary Concern(s):_____

I.Do you have currently any of the following Symptoms? If applicable, please circle which ear.

□ Difficulty Hearing	Left Ear	Right Ear	Both
□ Ear Pain	Left Ear	Right Ear	Both
□ Ear Drainage	Left Ear	Right Ear	Both
□ Ear Fullness/Pressure	Left Ear	Right Ear	Both
□ Tinnitus (noise in your ears/head)	Left Ear	Right Ear	Both
□ Problems with ear wax	Left Ear	Right Ear	Both

II. How important is it for you to improve your hearing right now? (Circle number)

Not very important 1 2 3 4 5 6 7 8 9 10 Very Important

III.How motivated are you to wear and use hearing devices? (Circle number)

Not very important 1 2 3 4 5 6 7 8 9 10 Very Important

IV. What is your most important consideration regarding hearing devices? Rank the following factors in the order of importance to you, with **1 as the most important and 4 as the least important**. Place an X on the line if the factor has no importance to you at all.

___Improved ability to hear and understand speech
___Hearing device size and the ability of others not to see the hearing devices
___Improved ability to understand speech in noisy situations (e.g., restaurants, parties)
___Cost of hearing devices

V. Please circle the statement that best relates to you:

1. I don't think I have a hearing problem
2. I have some difficulties with my hearing, but it does not affect my everyday life
3. I have a hearing problem and I have started to consider doing something to improve it
4. I have a hearing problem, it is disturbing and I would like to do something about it
5. I have a hearing problem and I am actively doing something to improve it

VI. For current hearing aid users:

How long have you worn hearing aids? _____

How old are your current hearing aids?_____

Do you wear one hearing aid or two?_____

Make/Model:_____

How often do you wear your hearing aids?_____

What would you want to improve about your current hearing aids?

_____

_____

Assignment of Benefits and HIPAA Notice

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information.

I acknowledge that I was offered and/or provided a copy of the Notice of Privacy Practices for Ohio Ear Institute.

_____
Patient Name

_____ _____
Signature Date

Communication Preferences:

To assist in your care, it may be necessary to release your Protected Health Information to someone other than yourself. Who may we talk to?

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

May we communicate with you by:

Leaving a message on your answering machine/voice mail at home ☐ Yes ☐ No

Sending you an email ☐ Yes ☐ No

Sending you a text message ☐ Yes ☐ No

Sending you our periodic newsletter ☐ Yes ☐ No

_____
Patient Name

_____ _____
Signature Date