4011 E. Renner Rd Suite 108
Richardson, TX 75082
Main: 972-803-8072
Fax: 214-238-3806

915 W. Exchange Pkwy Suite 180-A
Allen, TX 75013
Main: 972-747-1333
Fax: 972-747-1132

Patient Information

Patient Name:			Date of Birth:
Address:			Gender: ☐ Male ☐ Female
City:		State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	May we send text reminders?
Email:			May we contact you by email?
Emergency Contact:		Relationship:	Phone:
Primary Care Physician:		Phone:	May we send report to doctor?

With whom may we share your information

I authorize Gomer Hearing Center to discuss diagnosis, treatment plans, and/or business billing issues, either in person and/or via telephone or email, with the follow persons other than myself (patient). If the patient is a minor, parent(s) and/or guardian(s) must be listed. ****If family members, friends, caretakers, etc.are not listed below, we will be unable to share information regarding your health, test results, recommendations, and any hearing devices pertaining to your care with them.***

Printed Name	Relationship	Phone

☐ **NO HEALTH AND/OR BUSINESS INFORMATION IS TO BE RELEASED OR DISCUSSED WITH ANYONE OTHER THAN THE PATIENT AND/OR ACCOMPANYING PARENT IN THE CASE OF A MINOR.**

Should I: 1) elect to change the person(s) listed above, I understand I must contact Gomer Hearing Center in writing to make a change;
2) wish to revoke this authorization in the future, it will not affect any action Gomer Hearing Center took in reliance on this authorization before a notice of revocation or change in person(s) listed was received.

Patient Signature: ______________________________ Date: ____________________

Notice of Privacy Practices and Financial Responsibilities

By initialing this section and signing below,

- I hereby acknowledge that I have received and read (or declined to read) the Gomer Hearing Center Notice of Privacy Practices, Policies and Procedures and that I understand my rights and responsibilities as outlines by this document. **Initials** ________
- I allow Gomer Hearing Center to render the services I am requesting. I acknowledge that deductibles, co-pays, coinsurance, or payment in full, is due at the time of service. I understand that refusal to sign this release grants Gomer Hearing Center the right to decline services that may be in my best interest. **Initials** ________
- I allow Gomer Hearing Center to file my claim to my insurance carrier. If the claim is denied, Gomer Hearing Center will appeal once on my behalf. If the claim continues to be denied, I will be billed for the balance owed and will appeal the claim with my insurance myself. **Initials** ________
- I authorize Gomer Hearing Center to send me educational information on the products and services offered by Gomer Hearing Center. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time. **Initials** ________
- I understand that I must provide Gomer Hearing 24-hour notice to change or cancel an appointment. If I do not provide 24-hour notice to change or cancel my appointment, or if I miss my appointment time without prior notification, I will be billed a $25 service charge. **Initials** ________

Patient Signature: ______________________________ Date: ____________________

Medical History and Hearing Handicap

Referred By

Please check all that apply

○ Internet – Name of Site: ___________________________ ○ Sign ○ Flyer

○ Insurance – Name: _______________________________ ○ Newspaper ○ Health Fair

○ Friend/Family – Name: ___________________________ ○ Radio ○ Other:

○ Doctor – Name: ____ Phone: __________________________

Current Medications

List ALL medications currently prescribed to you by any doctor. Please include any vitamins and/or supplements.

Medication Name	Strength	Times Taken Per Day

Medical History

Please ANSWER or CHECK any condition below that applies to your personal medical history and briefly explain in the space provided.

Have you had a hearing test? YES or NO If so, when?

Do you experience hearing loss? YES or NO If so, which ear? □ Right Ear □ Left Ear □ Both Ears

If you experience hearing loss, which best describes it? □ Gradual □ Fluctuating □ Sudden

If gradual, when did it begin?

If fluctuating, when did it being? Please describe fluctuations.

If sudden, when did it occur? Please describe what occurred.

Please CHECK and answer any questions if you are currently experiencing or have ever experienced:

□ Ear pain? □ Right Ear □ Left Ear
When began?

□ Ear infections? □ Right Ear □ Left Ear
When?

□ Ear drainage? □ Right Ear □ Left Ear
When?

□ Ear surgery? □ Right Ear □ Left Ear
When? Reason?

□ History of noise exposure? Please describe:

□ Family history of hearing loss? Please explain:

□ Dizziness or unsteadiness: How often? When did it first occur?

If checked above, is it accompanied by: □ Vomiting □ Nausea □ Ear noises

□ Tinnitus/Ringing/Ear Noises? □ Right Ear □ Left Ear □ Both When did it began?

Does it fluctuate? YES or NO How often does it occur?

□ Diabetes?	□ Hypertension?	□ Sinusitis?	□ Heart Surgery? When?
□ Heart disease?	□ Chronic pain?	□ Stroke?	□ Cancer? Type:
□ Measles?	□ Migraines?	□ Meningitis?	□ Head injury? When?
□ Thyroid disease? (Hyper/Hypo)			

Hearing Handicap Inventory Screening Questionnaire for Adults

1) Answer No, Sometimes or Yes for each question.
2) Do not skip a question if you avoid a situation because of a hearing problem.
3) If you use a hearing aid, please answer according to the way you hear with the aid.

	No	Sometimes	Yes	
1. Does a hearing problem cause you to feel embarrassed when you meet new people?				
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?				
3. Do you have difficulty hearing / understanding co-workers, clients or customers				
4. Do you feel handicapped by a hearing problem?				
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?				
6. Does a hearing problem cause you difficulty in the movies or in the theater?				
7. Does a hearing problem cause you to have arguments with family members?				
8. Does a hearing problem cause you difficulty when listening to TV or radio?				
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?				
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?				
Total (Office use Only):				

*Adapted from: Ventry, I., Weinstein, B. “Identification of elderly people with hearing problems” American Speech-Language-Hearing Association. 1983, 25, 37-42

If we find your hearing could be helped by hearing devices, how open are you to trying a solution? □ Yes □ Possibly □ No

What type of phone do you have? □ Apple □ Android

Please check which features you may be interested in:

□ Rechargeable Options □ Performance □ Bluetooth/Smart Phone Capability □ Wireless Audio Streamers for TV

What else should we know before beginning your visit? Any questions or concerns you would like to discuss with your doctor?