



AMERICAN FAMILY HEARING CENTER

220 Monmouth Road, Suite 2, Oakhurst, NJ 07755

732.517.1200

americanfamilyhearing.com

Name:

DOB:

Address:

City:

State:

Zip:

Telephone:

E-Mail:

Social Security #:

Marital Status:

Emergency Contact:

Relationship:

Phone:

How did you hear about American Family Hearing Center?

Occupation:

Referring / Primary Doctor:

Would you like a report sent to your Dr.?

Primary Insurance

Policy#

Secondary Insurance

Policy#

*Your signature above attests to the following statement: "I request that payment of authorized Medicare / Insurance benefits be made on my behalf to American Family Hearing Center (Jennifer Schaal-Sampson, Audiologist) for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services."

Patient / Guardian Signature:

Date:



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Audiological History

- Will this be the first time you've had a hearing test? Yes No
If no, what year was your last test?
 - Do you have noise or ringing in your ears? Yes No
 - Do you have dizziness, vertigo, or balance issues? Yes No
 - Did you have chronic ear infections as a child or adult? Yes No
 - Do you have a family history of hearing loss? Yes No
 - Have you been exposed to a lot of noise in your life? Yes No
 - Have you had any trauma to the head? Yes No
 - Do you have sinus or allergy issues? Yes No
 - Do you have difficulty hearing when someone whispers? Yes No
 - Does a hearing issue cause you difficulty when visiting with others? Yes No
 - Does a hearing issue cause you to attend services less often than usual? Yes No
 - Does a hearing issue cause you difficulty with TV or Radio? Yes No
 - Do you have hearing issues when dining in a restaurant? Yes No
 - Do you have difficulty hearing women or children? Yes No
 - In which ear do you hear well? Left Right
 - What do you believe caused your hearing problem?
 - Do you wear hearing aids? If yes Left Only Right Only Both Ears
 - What year did you currently buy your hearing aids?
 - Approximately how many hours a day do you wear them?
 - Do you have issues with your current hearing aids?
If yes, please explain:
 - Past or Present Occupation:
 - Have you had ear surgery? If yes, when? Which Ear? Procedure?
 - Why have you decided to have your hearing tested at this time?
 - I feel my hearing is poor and may need to be aided Yes No
 - Family and Friends have suggested I have my hearing checked Yes No
- Other reason, please explain:

Medical History

Have you had or currently have any of the following:

High Blood Pressure	Heart Disease	Stroke	Arthritis	Diabetes	Kidney Disease
Cancer	Mumps	Measles	Meningitis	General Anesthetic	Pace Maker

Please list any Medications that you take and why?



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Better Hearing Questionnaire

Following you will find a list of important factors to consider when purchasing a hearing instrument. Please rate them in order of importance from 1 to 6, by placing the #1 next to the most important factor, the #2 to next to the second most important factor and so on through #6, which would be the least most important factor to you.

Understanding Speech Better:

Function in Noisy Environment:

Inconspicuous Appearance:

Cost:

Comfort:

Service:

Lifestyle and Listening Needs

Please select the response which best describes your lifestyle: Fill in 1 - Seldom, 2 - Occasionally and 3 - Often	
I am actively working and need to communicate with many people.	
I spend time at sporting events or other loud activities where I need to hear in the presence of a great deal of background noise.	
I attend large parties or go to busy restaurants where I need to communicate.	
I go shopping or spend time in public places where being able to communicate is important.	
I am involved in religious gatherings where I need to be able to hear.	
I attend work or social meeting where I need to be able to communicate.	
I need to hear in quiet situations.	
I need to be able to communicate in small group settings.	
I need to be able to hear the television.	
I need to be able to hear in one-on-one settings.	
I spend quite a bit of time involved in quiet home activities.	
I need to be able to hear on the telephone.	

Your Score:

10 or Less=Basic

11-19=Moderate

20-27=Advance

28-36=Premium

Thank you for helping us help you hear better!



Acknowledgment of Receipt of HIPAA Notice of Privacy Practices 2016

I wish to be contacted in the following manner (check all that apply):

Home Telephone

- Ok to leave message with detailed information
- Leave message with call-back number only

Written Communication

- Ok to mail to my home address
- Ok to mail to my work / office address
- Ok to fax to this #:

Work Telephone

- Ok to leave a message with detailed information
- Leave message with call-back number only

Cell Phone

- Ok to leave message with detailed information
- Leave message with call-back number only

Person Authorized to Receive Information

Print Name:

Relationship:

Print Name:

Relationship:

I do not wish to share information

Printed Name:

Signature:

Date:

Witness:

Patient Date of Birth:

Patient Disclosure Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.