UNIVERSAL HEARING CARE
Audiology and Hearing Aid Services

Patient Information

Patient Name

Address | City | State | Zip

Date of Birth | Email

Home Number | Mobile Phone

Spouse's Name | Phone Number

In Case Of Emergency | Relationship | Phone Number

Physicians Name

Address | City | Phone Number

Primary Insurance | I.D. #

Secondary Insurance | I.D. #

Employer | Phone Number

Who referred you to our office?

Please answer the following questions:

Do you have noise in your ears?	○ Yes	○ No
Have you been exposed to high levels of noise?	○ Yes	○ No
Do you have a history of ear infections?	○ Yes	○ No
Have you had surgery on your ears?	○ Yes	○ No
Do you have any pain in your ears?	○ Yes	○ No
Do you have dizziness?	○ Yes	○ No
Do you think you have hearing loss?	○ Yes	○ No
Did the hearing loss come on suddenly?	○ Yes	○ No
Do you wear a pacemaker?	○ Yes	○ No

☐ I authorize Universal Hearing Care, Inc. to release to my insurance company any information required in the processing of claims. I hereby authorize insurance payment directly to Universal Hearing Care, Inc. I shall be responsible for any co-payments, deductible, and/or non-covered services.

☐ I hereby acknowledge Universal Hearing Care's notice of Privacy Practices.

I wish to receive a copy of Universal Hearing Care's notice of Privacy Practices. ○ Yes ○ No

Signature | Date

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Patient Profile

What brought you to our office today? _____

Please check the appropriate boxes below that apply to your current hearing abilities in various environments.

Select One: ○ With hearing devices ○ Without hearing devices

Listening Environments	How well do you currently hear in this listening environment?			How frequently are you in this listening environment?		
	WELL	FAIR	POOR	OFTEN	SOMETIMES	RARELY
One on One Conversations	○	○	○	○	○	○
Quiet Room (1-2 people)	○	○	○	○	○	○
Small Groups (4-6 people)	○	○	○	○	○	○
Large Social Gatherings	○	○	○	○	○	○
At the Work Place	○	○	○	○	○	○
Watching Television	○	○	○	○	○	○
During Religious Services	○	○	○	○	○	○
Meetings/Lectures	○	○	○	○	○	○
In the Car	○	○	○	○	○	○
Outdoors	○	○	○	○	○	○
On the Telephone	○	○	○	○	○	○

What is your experience with hearing devices? (Select all that apply)

☐ I have never used or visited a hearing healthcare professional to inquire about a hearing device(s).

☐ I have been to another hearing healthcare professional to gather information regarding my hearing difficulties, but have not tried or purchased.

☐ I have tried a hearing device(s) but returned the instrument(s).

☐ I have a hearing device(s) but only wear it occasionally or not at all.

☐ I have a hearing device and wear it regularly on the ○ Right Ear ○ Left Ear ○ Both

Please rank the following in terms of their importance in a hearing device. (1 through 4, with 1 being the most important)

Overall Sound Quality _____ Reliability _____ Style/Appearance _____ Cost _____

How motivated are you regarding doing something about your hearing loss?

○ Not Motivated ○ Somewhat Motivated ○ Motivated ○ Very Motivated ○ Extremely Motivated