Patient Information

Name: ____ DOB: _______________
Address: ____
City: ____________________ State: ____________ Zip Code: ____________

☐ *Please do **NOT** send mail from Hear For You Audiology & Hearing Aid Services to the address above.*

Phone Number: _______________________________ Email: _________________________________

☐ *Please do **NOT** send emails from Hear For You Audiology & Hearing Aid Services to the address above.*

Marital Status: _______________________________ Employment Status: _________________________

Insurance: Please indicate the subscriber to the policy

☐ Self ☐ Spouse ☐ Other _________________________

Subscriber's Name: ____ DOB: ________________
Policy Holder's Address: ____
City: ____________________________________ State: __________ Zip Code: _____________
Policy Holder's Phone #: _______________________ Employer: _______________________________

Medical Information

Primary Care Physician: _______________________________ Location: ________________________

Please list any medications you are currently taking *list any RX's including any OTC, herbal, vitamins, supplements, etc.*			
Name	Dosage	Frequency	Route Administered

Are you a Veteran? ☐ Yes ☐ No Do you receive medical services from the VA? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you experience ringing or noises in your ears? ☐ Yes ☐ No

When was your most recent hearing test? ____
Do you currently wear hearing aids? ☐ Yes ☐ No Make/Type: ___________________________
Reason for visit: ____
How did you hear about us? ____

The above information is accurate and to the best of my knowledge

Patient Signature: ____ Date: ____________________