HEAR FOR YOU
Audiology & Hearing Aid Services

Patient Information

Name: _____ DOB: _____

First Middle Last

Address: _____

Street City State Zip Code

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

Phone Number 1: _____ Email: _____

Phone Number 2: _____

☐ *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? _____

If you brought a companion to your appointment, list their name/relationship: _____

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

Patient Signature: _____ Date: _____