Better Hearing Questionnaire

Our concern is your hearing and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete both pages and return to the front desk.

Name: ____
(Last) (First) (Initial)

Date: ______________________ **Date of Birth:** ______________
(M/D/Y)

Mailing Address: ______________________________________
(City) (State) (Zip)

Local Telephone #: ____________________ **Cell Phone #:** ______________

Local Doctor: ______________________________________

Hearing Aid Insurance/Health Plan: ______________ **Policy #:** ______________

How did you hear about us? ______________________________

Your e-mail address: ______________________________

Name of family member/friend with you today: ______________________

Relationship to you: ______________________________

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