# Adult Intake Form

**Date:** ________________

**Name:** ______________________________________________________ **DOB:** _________________
(Last) (First) (MM/DD/YYYY)

**Mailing Address:** ______________________________________________________________________
(Street) (Unit)

______________________________________________________________________
(City) (State) (Zip)

**Preferred Telephone #** _______________________
Circle: Cell Home Work

**Alternative Telephone #** _______________________
Circle: Cell Home Work

**Email Address:** ________________________________________________________________________

**Occupation (past/present):** ______________________________________________________________

**Referring Physician (Name/Address/Phone):** _____________________________________________

_____________________________________________

## On a scale of 1-10 (1 - Not Important, 10 - very important)

____ How important is it to you to solve your hearing/tinnitus problem?

____ How important is it to your close family that you solve your hearing/tinnitus problem?

____ How important is it to your friends or colleagues that you solve your hearing/tinnitus problem?

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# Hearing Handicap Inventory for Adults (HHIA)

## Instructions:

1. Answer by checking **YES, SOMETIMES, or NO** in the associated box; answer the following prompt if shown.
2. **If you use a hearing aid**, please answer accordingly to the way you hear **without** the aid.

| **Questions:** | **YES** | **Sometimes** | **NO** |
|---|---|---|---|
| Does your hearing/tinnitus problem cause you to use the phone less often than you would like? | | | |
| Does your hearing/tinnitus problem make you feel embarrassed when meeting new people? | | | |
| Does your hearing/tinnitus problem cause you to avoid groups of people? | | | |
| Does your hearing/tinnitus problem make you irritable? | | | |
| Do you feel frustrated when talking to family members? | | | |
| Does your hearing/tinnitus problem make it difficult to hear at parties? | | | |
| Does your hearing/tinnitus problem cause difficulty hearing/understanding coworkers, clients, or customers? | | | |
| Does your hearing/tinnitus problem make it frustrating when talking to others? | | | |
| Do you feel handicapped by your hearing/tinnitus problem? | | | |
| Do you have difficulty hearing in the movies or theater? | | | |
| Does your hearing/tinnitus problem cause you to be nervous? | | | |
| Does your hearing/tinnitus problem cause arguments with family members? | | | |
| Does your hearing/tinnitus problem ever cause you to be upset? | | | |
| Does your hearing/tinnitus problem make you not be yourself? | | | |
| Do you feel like your hearing/tinnitus problem limits or hampers your personal or social life? | | | |
| Do you have difficulty hearing in restaurants? | | | |

| Questions (Continued) | Yes | Sometimes | No |
|---|---|---|---|
| Does your hearing/tinnitus problem cause you to feel depressed? | | | |
| Do you watch less TV or listen to the radio less because of your hearing/tinnitus problem? | | | |
| Does your hearing/tinnitus problem make you feel uncomfortable when talking to others? | | | |
| Do you feel left out in a group of people? | | | |
| Do you ever feel dizzy or lightheaded? | | | |
| Have you fallen recently (in last 12 months)? | | | |

## Assessment Of Priorities Relating to Hearing Correction

Please rank the following important factors where you would like to see improvement.

**On a scale of 1-6 (1 - Not Important, 6 - very important)**

Understanding speech better ______

Inconspicuous Appearance ______

Comfort ______

Function in noisy environment ______

Cost ______

Service ______

## Medical/Audiologic History

| | YES | NO |
|---|---|---|
| Will this be the first time you've had a hearing evaluation?<br><br>➢ If no, what year were you last tested? ________________________________ | | |
| Have you ever had ear surgery?<br>➢ If yes, when? Which ear? Procedure? _________________________________ | | |
| Do you have noises or ringing in your ears?<br>➢ If yes, is it in both ears? Right? Or left ear? ___________________________ | | |
| Did you have chronic ear infections as a child or adult? | | |
| Do you have a family history of hearing loss? | | |
| Have you been exposed to a lot of noise in your life? | | |
| Have you had any trauma to the head?<br>➢ If yes, please explain: _____________________________________________ | | |
| Do your ear canals itch? | | |
| Do you have sinus or allergy problems? | | |
| Do you have problems with dizziness or a feeling of being lightheaded? | | |
| Do you have a history of falling? | | |
| Do you have difficulty hearing when someone speaks in a whisper? | | |
| Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? | | |
| Does a hearing problem cause you to attend church less often than you would like? | | |
| Does a hearing problem cause you difficulty when listening to TV or radio? | | |
| Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? | | |
| Do you have difficulty hearing women or children? | | |

| Do you wear hearing aids?<br>➢ If yes, circle: left only right only both ears<br>➢ What year did you buy your hearing aids? ______________<br>➢ How many hours a day do you wear them? _____________ | | |
|---|---|---|
| ➢ Do you have any problems with your hearing aids?<br>If yes, explain: ____________________________________________________<br>____________________________________________________________ | | |
| What do you believe caused your hearing problem? | | |
| In which ear do you hear better? circle left right | | |

## Medical History

Have you had or currently have any of the following (check all that apply):

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Arthritis
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Mumps
- ☐ Measles
- ☐ Meningitis
- ☐ General Anesthetic
- ☐ Dizziness/Vertigo

| List of Medications | |
|---|---|
| **Medication** | **Condition** |
| | |
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# Insurance Authorization and Financial Policy

Thank you for choosing North Houston Hearing Solutions as your audiology provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Read, agree to, and sign prior to testing or fitting of hearing aids.

**OFFICE SERVICES:** Responsibility for payment of your bill is your obligation regardless of insurance coverage. Insurance is filed as a courtesy to you. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims. We want to make sure, however, that you understand payment for service is your responsibility. You will be responsible for all non-covered services, amounts exceeding allowed charges, co-pays, and deductibles, including Medicare. All co-pays are due at the time of service.

**CASES INVOLVING LITIGATION:** We consider the patient, not the attorney, to be responsible for all fees.

**INSURANCE AUTHORIZATION:** I hereby authorize North Houston Hearing Solutions to furnish information to my insurance carriers and physicians concerning my illness or treatment, or my child's illness or treatment.

I acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If, for any reason, the account should become delinquent, I agree to pay all collection and legal fees. I have read, understood, and agree to the above Financial Policy.

**I have read and received a copy of Notice of Privacy Practices.**

**Signature:**_______________________________________________ **Date:** ____________________

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## Appointment of Representative

**I appoint North Houston Hearing Solutions to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize North Houston Hearing Specialists to make any request; to present or elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to North Houston Hearing Solutions.**

**Signature of Patient:** _________________________________ **Date:** ________________

**Printed Name of Patient:** ____________________________________________________

**Street Address (plus City, State, Zip):** __________________________________________

__________________________________________

**Phone Number:** ___________________________________________________________

**Email Address:** ____________________________________________________________

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