

Adult Intake Form



Date: _____ DOB (MM/DD/YYYY): _____

First Name: _____ Last name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone #: _____ Cell Home Work

Alternative Telephone # _____ 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?

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?			

Questions (Continued)	YES	Sometimes	NO
Do you have difficulty hearing in restaurants?			
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? · If no, what year were you last tested? _____		
Have you ever had ear surgery? · If yes, when? Which ear? Procedure? _____		
Do you have noises or ringing in your ears? · If yes, is it in <input type="checkbox"/> Both ears <input type="checkbox"/> Right <input type="checkbox"/> 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? · 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?		

<p>Do you wear hearing aids?</p> <p>· If yes: <input type="checkbox"/> Left only <input type="checkbox"/> Right only <input type="checkbox"/> Both ears</p> <p>· What year did you buy your hearing aids? _____</p> <p>· How many hours a day do you wear them? _____</p>		
<p>· Do you have any problems with your hearing aids?</p> <p>If yes, explain: _____</p>		
<p>What do you believe caused your hearing problem?</p>		
<p>In which ear do you hear better? <input type="checkbox"/> Left <input type="checkbox"/> Right</p>		

Medical History

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

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Dizziness/Vertigo |

List of Medications



Medication	Condition

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: _____

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: _____