HEARING SERVICES OF SANTA BARBARA

Intake Form

Patient Name _____ Sex ☐ M ☐ F
First MI Last

Address _____
Street City State Zip

Home Phone _____ Cellphone _____

Email _____ SSN _____

Date of Birth _____ Marital Status ☐ Married ☐ Single ☐ Widowed

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Relationship to Patient _____ Primary Care Physician _____

Is this your first hearing aid evaluation? ☐ Yes ☐ No

Have you been examined by an ear specialist in the last year? ☐ Yes ☐ No

Have you ever worn hearing aids? ☐ Yes ☐ No

Do you have any of the following?

Deformity of the ear	☐ Yes ☐ No	Pain or discomfort in either ear	☐ Yes ☐ No
Ear drainage	☐ Yes ☐ No	Hearing loss in one ear only	☐ Yes ☐ No
Sudden hearing loss in the past 90 days	☐ Yes ☐ No	Wax removed by a physician	☐ Yes ☐ No
Acute or chronic dizziness	☐ Yes ☐ No	Tinnitus / ringing in the ears	☐ Yes ☐ No

How did you find out about us?

☐ Yellow Pages	☐ Internet	☐ Referred by Patient _____
☐ Advertisement	☐ Insurance	☐ Referred by Physician _____
☐ Employer	☐ Other _____	

☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.

Patient Signature _____ Date _____