Ascent HEARING CENTER

4 CONVENIENT LOCATIONS
Crown Point • Lowell • Schererville • Valparaiso
PHONE (219) 462-6866
www.HelpMeHear.net.

Trent Harris, Owner

Confidential Client Information

1 Patient Information

Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Gender: _____ Occupation/Former Occupation: _____

Primary Insurance: _____ Insured Name: _____

How did you hear about us? ☐Patient ☐Newspaper ☐Direct Mail ☐Community Event ☐Physician Referral ☐Website

Emergency Contact Name: _____ Phone: _____

2 Medical History

Have you seen a doctor specializing in diseases of the ear (ENT): ..... Yes No

Name of Primary Care or Referring Physician: _____

Have you ever had ear surgery: Yes No By whom: _____ When: _____

Have you had a hearing test: Yes No By whom: _____ When: _____

3 About Your Hearing

Do you have a deformity of the ear?..... Yes No

Do you have any pain in your ears? ..... Yes No

Sudden or rapid hearing loss in the past 90 days? ..... Yes No

Sudden or long-term dizziness? ..... Yes No

Hearing loss in one ear in the last 90 days? ..... Yes No

Have you seen a doctor for wax removal? ..... Yes No

Drainage from either ear in the past 90 days? ..... Yes No

Is one ear worse than the other?..... Right Left Same

Do you have ringing or other noises in your ear(s)? If so, which side?..... Right Left Same

Does anyone else in your family have a hearing problem? If Yes, who?_____

4 Hearing Aid History

Is this your first time using a hearing aid. ..... Yes No

Do you have a hearing aid and use it regularly. ..... Yes No

Do you have a hearing aid but don't use it often..... Yes No

Have you tried a hearing aid but then returned it..... Yes No

Have you inquired about hearing aids at another facility but did not purchase. Yes No