NEW WAVE
HEARING AIDS

Intake Form

Patient Name ______________________________ Date of Birth ____________
First Last MI

Address ____
Street City State Zip

Home Phone ____________________ Cell Phone ____________________

Email ______________________________ Sex ☐M ☐F

Employer Name & Address ______________________________

Work Phone ____________________

Marital Status ☐Married ☐Single ☐Widowed

Emergency Contact ____________________ Phone ____________

Relationship to Patient ______________________________

Primary Care Physician ____________________ Organization ____________

Check the boxes and sign below (Please give insurance cards to reception for copying)

I hereby Authorize payment of insurance benefits otherwise payable to New Wave Hearing Aids. I further understand I am financially responsible for all charges incurred, regardless of insurance coverage and/or status. ☐

I give permission to this practice to release information, verbal and written, contained in my medical record and or other related information to my insurance company, healthcare providers, assignees and/or beneficiaries and all other persons. Information without patient identifiers may be used for quality purposes. ☐

On occasion New Wave Hearing Aids sends out newsletters and information about our services. Please check this box if you do not wish to receive these mailings. ☐

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and herby give my permission to the practice to treat my concerns.☐

______________________________ ____________
Patient Signature Date

______________________________ ____________
Legal Guardian if Patient is a Minor Date

NEW WAVE HEARING AIDS

Have you seen a doctor for your hearing in the past six months? ☐Yes ☐No
Have you seen a doctor specializing in diseases of the ear? ☐Yes ☐No
Will this be your first hearing test? ☐Yes ☐No
Have you had ear surgery? ☐Yes ☐No
Do you take medicine every day? If so please list medications you take. ☐Yes ☐No

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Are you diabetic? ☐Yes ☐No
Are you nervous? ☐Yes ☐No
Do you have a heart condition? ☐Yes ☐No
Do you have any of the following: ☐Yes ☐No
Deformity of the ear? ☐Yes ☐No
Do your ears feel full? ☐Yes ☐No
Ear drainage? ☐Yes ☐No
Sudden or rapid hearing loss in the past 90 days? ☐Yes ☐No
Acute or recurring dizziness? ☐Yes ☐No
Do you ever have ear pain? ☐Yes ☐No
Have you ever had a doctor remove wax from your ear(s)? ☐Yes ☐No
In which ear is your hearing the worst? ☐Yes ☐No
Do we have your permission to send hearing test results to your doctor? ☐Yes ☐No

Hearing History:

Have you noticed that people seem to mumble? ☐Yes ☐No
Do you have tinnitus or ringing of the ears? ☐Yes ☐No
Do you sometimes hear words but not understand them? ☐Yes ☐No
Do you find it difficult to hear in noisy places? ☐Yes ☐No
Do others complain you set the television too loudly? ☐Yes ☐No
Do you find it difficult to understand speech on the telephone? ☐Yes ☐No
Which ear do you use on the telephone? ☐Yes ☐No
Have you ever worked around loud noises? ☐Yes ☐No
List 3 areas you would like your hearing improved.

1. ______________________________

2. ______________________________

3. ______________________________

Is there any family history of hearing problems? ☐Yes ☐No
How many years have you experienced hearing difficulty?
Do you have a hearing aid? ☐Yes ☐No
When selecting a hearing system, I am most concerned with:

☐ the unit looking as small and inconspicuous as possible.
☐ the latest in technology.
☐ follow-up service from the office.
☐ price.

Patient Signature ______________________________ Date ___/___/______

HEARING HANDICAP INVENTORY FOR ADULTS (HHIA)

NAME: ______________________________ DATE: ______________

INSTRUCTIONS: The purpose of the scale is to identify the problems your hearing loss may be causing you. Check YES, SOMETIMES, or NO for each question. DO NOT skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear WITHOUT your hearing aid.

		YES (4)	Sometimes (2)	NO (0)
S-1	Does a hearing problem cause you to use the phone less often than you would like?			
E-2	Does a hearing problem cause you to feel embarrassed when meeting new people?			
S-3	Does a hearing problem cause you to avoid groups of people?			
E-4	Does a hearing problem make you irritable?			
E-5	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S-6	Does a hearing problem cause you difficulty when attending a party?			
S-7	Does a hearing problem cause you difficulty hearing/understanding coworkers, clients, or customers?			
E-8	Do you feel handicapped by a hearing problem?			
S-9	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
E-10	Does a hearing problem cause you to feel frustrated when talking to coworkers, clients, or customers?			
S-11	Does a hearing problem cause you difficulty in the movies or theater?			
E-12	Does a hearing problem cause you to be nervous?			
S-13	Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			
E-14	Does a hearing problem cause you to have arguments with family members?			
S-15	Does a hearing problem cause you difficulty when listening to TV or radio?			
S-16	Does a hearing problem cause you to go shopping less often than you would like?			
E-17	Does any problem or difficulty with your hearing upset you at all?			
E-18	Does a hearing problem cause you to want to be by yourself?			
S-19	Does a hearing problem cause you to talk to family members less often than you would like?			
E-20	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S-21	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
E-22	Does a hearing problem cause you to feel depressed?			
S-23	Does a hearing problem cause you to listen to TV or the radio less often than you would like?			
E-24	Does a hearing problem cause you to feel uncomfortable when talking to friends?			
E-25	Does a hearing problem cause you to feel left out when you are with a group of people?			

<u>Medical Waiver</u>

I have been advised by the professional noted on this document that the Food and Drug Administration has determined that my best interest would be served if I have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish to have a medical evaluation before purchasing a hearing aid.

Patient Signature: ___________________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I mat request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do then you are bound to abide by such restrictions.

Patient Name: ______________________________________

Signature: ________________________________

Date: ______________________ Relationship to Patient: ____