

Hearts for Hearing
3525 NW 56th, Suite A-150
Oklahoma City, OK 73112
(405) 548-4300 phone
(405) 548-4350 fax



Appointment Date: _____ Who are you seeing today _____

Patient Name _____ Gender _____ Date of Birth _____

Language _____ Social Security _____ Primary Care _____

County of Residence _____ Referred By _____

Address _____ City _____ ST _____ Zip Code _____

Home Phone () _____ Work Phone () _____ Cell () _____

Email _____ Emergency Contact _____

Address _____ Phone () _____ Relationship _____

Guarantor (if different from patient)

Name _____ Relationship _____ Gender _____

Date of Birth _____ Social Security _____ Home Phone () _____

Address _____ Cell Phone () _____

Employer _____ Work Phone () _____

Insurance-Carrier Name _____ Address _____

Policy _____ Group _____ Effective Date _____

Subscriber's Name _____ Relationship _____ Social Security _____

Date of Birth _____ Address (if different) _____

Secondary-Carrier Name _____ Address _____

Policy Number _____ Group _____ Effective Date _____

Subscriber's Name _____ Relationship _____ Social Security _____

Date of Birth _____ Address (if different) _____

I authorized my insurance benefits to be paid directly to Hearts for Hearing. I understand that I am financially responsible for any balance. I authorize Hearts for Hearing or my insurance company to release any information needed to process my claims. I give permission to you and any agent of Hearts for Hearing, to call me on any phone number I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. Signature _____ Date _____

Check here if you do not wish to receive occasional mailings from Hearts for Hearing (Newsletters, events, etc.)

HEARING HISTORY

Are you currently under the care of the following professionals? (Check all that apply)

- ___ Audiologist
- ___ Speech–Language Pathologist
- ___ Otologist/ENT
- ___ Physician
- ___ Other (Psychologist, OT, PT, etc.)

Do you currently wear hearing aids?
Yes No

If yes, in which ear do you wear a hearing aid?
(circle all that apply): Right Left

What is your primary mode of communication?
Spoken language Sign language

Describe the cause and duration of hearing loss (if known): _____

MEDICAL HISTORY

Indicate with an “H” if you **have had** (as a child or adult) any of the following illnesses, or indicate with an “√” if you have been **immunized** against these illnesses:

Allergies	Chicken Pox	Ear Infections	Encephalitis	Polio
Asthma	Convulsions/Seizures	Ear Pain	Measles	Rubella
Cancer	Dizziness/Vertigo	Ear Surgery	Mumps	Scarlet Fever

WHAT WOULD YOU LIKE TO LEARN FROM TODAY’S VISIT?

The above information is true and complete to the best of my knowledge. Additionally, I am aware of this office’s Notice of Privacy Practices and fully understand my privacy rights as a patient of Hearts for Hearing.

Signature

Date

Relationship to Patient (Self, Spouse, etc)

Hearts for Hearing
www.heartsforhearing.org

