Swank Family Hearing

Established Patient Intake

Name _____
First MI Last

Preferred Name _____ Primary Care Physician _____

Date of Birth _____ Social Security Number _____

Your Mailing Address _____
Street City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Work Email Address _____

Insurance Company _____ Policy Number _____

Secondary Insurance _____ Policy Number _____

Health History

What is your primary reason for coming in today? _____

Do you have a better hearing ear? ☐ R ☐ L ☐ No

Have you experienced any changes to your hearing since your last evaluation? ☐ R ☐ L ☐ Both ☐ No

Have you had any ear surgery?	☐ Yes	☐ No	If yes, please explain _____
Do you suffer from ear pain or discomfort?	☐ Yes	☐ No	Have you been exposed to excessive noise in the last 16 hours? ☐ Yes ☐ No
Do you have any fullness/pressure in your ears?	☐ Yes	☐ No	
Do you have dizziness/vertigo?	☐ Yes	☐ No	Do you notice ringing/sounds in your ears? ☐ Yes ☐ No
Do you have concerns regarding your hearing aids?	☐ Yes	☐ No	If yes, please explain _____

Please review and check the following boxes:

☐ I give permission to this practice to release verbal or written information contained in my medical record and other related information to my insurance company, health care providers, assignees, beneficiaries and all other related persons.

☐ I allow for voice messages from this practice to be left on any provided phone number.

☐ I acknowledge that I have had the opportunity to review a copy of the Swank Family Hearing's privacy notice. (Available in our office and on our website.)

☐ I acknowledge that I have had the opportunity to review a copy of the Swank Family Hearing's patient rights & responsibilities. (Available in our office and on our website.)

☐ I allow the following individuals (e.g., spouse, family members, caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless Swank Family Hearing is notified otherwise.

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☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Swank Family Hearing. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by Swank Family Hearing.

_____ _____
Signature of Patient, Parent or Legal Guardian Date