Elk Grove HEARING CARE

Intake Form

Patient Name _____ Date of Birth _____
First Last MI

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ Sex ☐ M ☐ F

Marital Status ☐ Married ☐ Single

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____ Organization _____

How did you find out about us?

☐ Employer ☐ Yelp ☐ Referred by Patient _____

☐ Advertisement ☐ Website ☐ Referred by Physician _____

☐ Consumer Seminar ☐ Facebook ☐ Google

☐ Other _____

Check the boxes and sign below

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

On occasion Elk Grove Hearing Care 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 hereby give my permission to the practice to treat my concerns.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian if Patient is a Minor Date

Elk Grove HEARING CARE

How much difficulty do you have hearing in the following situations? If you wear hearing aids, please respond regarding your performance while wearing hearing aids.

	No difficulty	Slight difficulty	Moderate difficulty	Quite a lot of difficulty	Very much difficulty	Not relevant
One to one conversation	☐	☐	☐	☐	☐	☐
Conversation in small groups	☐	☐	☐	☐	☐	☐
Conversation in large groups	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
Concert/movie	☐	☐	☐	☐	☐	☐
Place of worship/lectures	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
In a car	☐	☐	☐	☐	☐	☐
Workplace	☐	☐	☐	☐	☐	☐
Telephone - Landline	☐	☐	☐	☐	☐	☐
Telephone - Mobile	☐	☐	☐	☐	☐	☐
Restaurant/café	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	

In which 3 environments would you like to hear better? SCALE OF 1-4

1. _____

2. _____

3. _____

How important is it for you to hear better? Mark an X on the line.

Not very important ---------- *Very Important*