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 ☐ Widowed

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

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 ____________________	☐	☐	☐	☐	☐	☐

TRACA (Their Reported Assessment of Communication Abilities) by EARtrak ©2014

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? Check the box on the line.

Not very important -- *Very Important*

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