90 Madison Street Suite 107 Denver, CO 80206
303-832-2054 Fax 303-377-1179
www.denveraudiology.net

Primary Insurance______________________________________ID#___________________CoPay: $_____
Customer Service Phone #: ___________________________
Secondary Insurance____________________________________ID#___________________CoPay:$_____
Customer Service Phone #: ___________________________

Patient Intake Form

Name: Mr., Mrs., Miss, Ms.____Date____________________

Address:____

____

Phone: (H)______________________________(C)________________________________(W)_____________________

Email:____Date Of Birth:_________________________________

Employer:______________________________________Referred by:__________________________________

Primary Care Physician:____

Reason for going to the referring physician?____

What is the reason for today's visit?____

Has your hearing been tested before today? YES /NO

Do you believe you have a hearing loss? YES/NO

In what situations do you notice or have difficulty? Telephone, radio/TV, conversation in noisy environment, male voice, female voice, other____

Which ear do you hear better with? ____R L Both same

Has the hearing loss been gradual, sudden, fluctuating?

Do you think your hearing has changed within the last year? YES/ NO

Reason?____

Any sudden or rapid hearing loss in the last 90 days? YES/ NO

Have you ever found it necessary to have wax removed? YES /NO

Do you hear noises in your ears or head? YES NO

Which ear? R L Both__________

Buzzing, Hissing, Ringing, Roaring, Pulsing, Rushing Water, Crickets, Thumping, Other____________________

Does hearing fluctuate or remain same?____

Any dizziness? YES NO Vertigo? YES NO Accompanied by: Nausea, Vomiting, Noises in Ear , Other____________

____

Have you ever experienced any of the following in the ear?
Fullness, Pain, Itching, Discharge R L Both
Have you ever had ear infections? YES /NO R L Both
As a child? Adult? How were they treated? ______________________________

____

Do you currently wear hearing aids? YES NO How long? Co.? ______
Hearing Style? R L Both
Exposed to loud noises? YES NO Firecrackers, Headphone Stereo, Guns , Concerts, (Military/Hunting), Motorcycles, Industrial Noises, Lawn Mower, Other ______________________________

____

Have you worn hearing protection for any of the above? YES NO
Does anyone in your family have a hearing loss? YES NO
Have you ever had a serious head injury? YES NO
Lost consciousness? YES /NO Cause? ______________________________
Convulsions/Seizures? YES /NO Cause? ______________________________
Have you been away from loud noise for 14-16 hours prior to today's assessment? YES NO
Allergies? YES NO LIST: ______________________________

____

Diabetes? YES /NO Age diagnosed? High Blood Pressure? YES NO
Any diseases or illnesses you have had and the age contracted (i.e. mumps, measles, meningitis, scarlet fever) ______________________________

____

____

Other Pertinent History/Information: ______________________________

____

____

I authorize treatment of person named below and agree to pay fees for treatment that has been completed. I hereby authorize my insurance benefits to be paid directly to the provider of service and understand that I am financially responsible for non-covered services. I also authorize release of medical information to my insurance company for claims processing, and to Denver Audiology, and my referring physician(s) for assessment and filing purposes.

____

Client Signature: Date:

For Office Use:
Otoscopy: NEG AU TFI: ______
Dizziness: Freq: Scale: /10 ______
Tinnitus: Freq: Scale: /10 ______
Family History: Noise Exp: ______
Ear Drainage: Ear Surgery: Otalgia: ______
Hearing Aids: Y N Yr Purch: Where: ______

PLEASE EMAIL COMPLETED FORMS TO patientcare@denveraudiology.net or bring completed forms with you to appointment. Thank you!