# PATIENT INTAKE FORM

This form complies with the Federal Health Insurance Portability and Accountability Act (HIPAA). This is a secure form; the information that you enter here will be seen only by the staff of our practice.

First name:

Last name:

Middle Initial:

Address line 1:

Address line 2:

City:

State: Zip:

Phone number:

Email address:

Gender: Male: ☐ Female: ☐

Birth date:

Marital Status: Single: ☐ Married: ☐

Current Occupation:

Emergency Contact Name:

Emergency Contact Phone Number:

Emergency Contact Relationship:

Referred By:

Referring Physician:

AMERICAN HEARING & BALANCE

americanhearingbalance.com | 213-536-4543

# ABOUT YOUR HEARING

Do you have any of the following symptoms?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Difficulty in hearing: | No: ☐ | Both: ☐ | Left: ☐ | Right: ☐ |
| Noise in hearing: | No: ☐ | Both: ☐ | Left: ☐ | Right: ☐ |
| Pain in hearing: | No: ☐ | Both: ☐ | Left: ☐ | Right: ☐ |
| Drainage from your ears: | No: ☐ | Both: ☐ | Left: ☐ | Right: ☐ |
| Fullness and stuffiness in your ears: | No: ☐ | Both: ☐ | Left: ☐ | Right: ☐ |
| Dizziness or balance problems? : | Yes: ☐ | No: ☐ | | |
| Had a previous hearing exam? : | Yes: ☐ | No: ☐ | | |

Previous Exam by: _____

Worn hearing aids before? : Yes: ☐ No: ☐

Previous hearing aid details: _____

# FINANCIAL INFORMATION

Cash or Insurance:

**PRIMARY INSURANCE**

Insurance Name:

Insurance ID #:

Insurance Group #:

Primary Subscriber's Name:

**SECONDARY INSURANCE**

Insurance Name:

Insurance ID #:

Insurance Group #:

Secondary Subscriber's Name: