

# Advanced Hearing Center

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Dallas, Texas 75252  
Phone: 972-733-3344 • Fax: 972-733-3852

Marilyn M. Hinrichs, Au.D., CCC-A  
Doctor of Audiology

## PATIENT INFORMATION

How did you hear about our office?  Insurance  Doctor - \_\_\_\_\_  Other \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Parent Name (if minor): \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # Home (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work # (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell # (\_\_\_\_)\_\_\_\_-\_\_\_\_

Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_ (Must have SS# for patient ID & insurance purposes) Sex: M F

## PHYSICIAN INFORMATION

Family Physician \_\_\_\_\_ Office # (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax # (\_\_\_\_)\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Primary Insured Name: \_\_\_\_\_

Primary's relationship to Patient:  Parent  Guardian  Spouse  Self (please complete info. below)

Primary Insured ID#: \_\_\_\_\_ Group# \_\_\_\_\_ Sex: M F DOB \_\_\_/\_\_\_/\_\_\_

Primary Insured Employer: \_\_\_\_\_ Marital Status:  Single  Married

Does patient have  Medicaid or  Medicare Coverage?  Yes  No

## **Release of Medical Records/Assignment of Insurance Benefits**

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
Insurance Company(ies)

And request that payment of authorized benefits be made to Marilyn M. Hinrichs, Au.D. d/b/a Advanced Hearing Center on my behalf, for any services provided to me or my dependent. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I understand that I am financially responsible **for any charges not covered by my managed care plan(s), all charges whether or not paid by my insurance and a forty percent (40%) charge for all debt collection.** I authorize the use of this signature on all insurance submissions and a copy of this authorization to be used in place of its original.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**MEDICAL HISTORY**

- 1) Has a doctor examined you in the past 6 months?  Yes  No
- 2) List all Medications you are taking \_\_\_\_\_
- 3) Do you have:  Diabetes  Epilepsy  Heart problems
- 4) Will this be your first hearing test?  Yes  No
- 5) Have you ever had ear surgery?  Yes  No (If yes, what)\_\_\_\_\_
- 6) Do you have any of the following:
  - i) ♦Deformity of the ear?  Yes  No
  - ii) ♦Sudden or rapid hearing loss in the past 90 days?  Yes  No
  - iii) ♦Acute or recurring dizziness?  Yes  No
- 7) Has your hearing in one ear worsened in the past 90 days?  Yes  No
- 8) Do you ever have ear pain?  Yes  No
- 9) Have you ever had wax removed from your ears by a doctor?  Yes  No
- 10) In which ear is your hearing the worst?  Left  Right  Same

**HEARING HISTORY**

- 1) Do people seem to mumble?  Yes  No
- 2) Do you find yourself asking people to repeat what they have said?  Yes  No
- 3) Do you sometimes hear words but do not always understand them?  Yes  No
- 4) Do you find it difficult to hear in noisy places?  Yes  No
- 5) Have you been told that you speak loud?  Yes  No
- 6) Is it difficult to understand speech when your back is to the speaker?  Yes  No
- 7) Do others complain that you play the TV too loud?  Yes  No
- 8) Have you occasionally missed the ringing of a telephone?  Yes  No
- 9) Do you find it difficult to hear when using a telephone?  Yes  No
- 10) Do you avoid social events because of hearing difficulty?  Yes  No
- 11) How many years have you experienced hearing difficulty? \_\_\_\_\_
- 12) How did your hearing loss develop?  Suddenly  Gradually
- 13) Do you know the cause of your hearing loss?  Yes  No
- 14) Do you have a hearing instrument?  Yes  No
- 15) If a hearing loss is discovered, are you ready for help?  Yes  No

**HEARING INSTRUMENT USER**

**(While wearing hearing instruments)**

- 1) Do you hear but have difficulty understanding?  Yes  No
- 2) Do you have difficulty understanding when two or more are talking?  Yes  No
- 3) Do you have difficulty understanding when in a crowd?  Yes  No
- 4) Do you have difficulty understanding at a distance?  Yes  No
- 5) Do you have difficulty knowing from which direction sounds are coming?  Yes  No
- 6) Do you have difficulty while using a telephone?  Yes  No
- 7) Does your own voice sound hollow and unnatural?  Yes  No
- 8) Do words often run together?  Yes  No
- 9) Do your hearing instrument(s) make sounds loud enough?  Yes  No
- 10) Are some sounds too loud?  Yes  No
- 11) Do your hearing instrument(s) make sounds tinny?  Yes  No
- 12) Do your hearing instrument(s) whistle?  Yes  No
- 13) Do your hearing instrument(s) make your ears sore?  Yes  No

**PATIENT HISTORY:**

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