UNIVERSITY PHYSICIANS
BROOKLYN, INC.

AUDIOLOGY INTAKE - ADULT

Patient Information Date: _____

Name: _____

Date of Birth: _____ Age: _____ Male / Female

Address: _____ City/State/Zip: _____

(Tel) _____ (Cell) _____ (Fax) _____

(Work) _____ (Email) _____

Occupation: _____

Insurance Information – please provide up with a copy of your insurance card at time of visit

Primary Insurance Company: _____ (Tel): _____

Name of Insured: _____ DOB of Insured: _____

Policy #: _____ Group #: _____

Claims Address: _____ City/State/Zip: _____

Primary/Referring Physician's

Physician's Name: _____ Please send report to my physician _____ Yes _____ No

Address: _____

(Tel): _____ (Fax): _____ Email: _____

Referred by (if different from physician above): _____

(Tel): _____ (Fax): _____ Email: _____

NOTICE OF PATIENT RESPONSIBILITIES

- You are responsible for all the fees associated with the care you receive.
- Payment is expected at the time of the service unless other arrangements have been made in advance.
- It is your responsibility to understand your benefits and all obligations set forth by your insurance company.

By signing below, I acknowledge that have read and understood the above information.

_____ _____

Print Patient's Name Signature

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REASON FOR REFERRAL/VISIT: _____

_____

When/where was your last hearing test? _____

Results of hearing test? _____

MEDICAL/AUDIOLOGIC HISTORY

History of Hearing Loss? Yes / No Ear: _____ Date/onset: _____

Have you received/been recommended for any surgical intervention? _____

Please check	Yes	No	If Yes - explain (which ear, how long, etc.)
Ear disease?	□	□	_____
Family history of HL	□	□	_____
Head trauma	□	□	_____
Noise exposure	□	□	_____
Dizziness/Vertigo	□	□	_____
Tinnitus/ringing	□	□	_____

How is your general health? _____

History of diabetes? _____

Present medications/ototoxic medications? _____

Recent hospitalizations / surgeries/chemotherapy? _____

Other medical conditions? _____

_____

_____

HEARING AID INFORMATION

Do you wear hearing aids? Yes / No Ear: Right / Left How long? _____

Type of Hearing Aid: □ Digital □ Programmable □ Analog

Style of Hearing Aid: □ Behind-the-ear □ In-the-ear □ open fit

Are you satisfied with current amplification? _____

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HEARING DIFFICULTY QUESTIONNAIRE

Listening Situations	Hearing Quality (1) Poor - (5)Normal	Importance to You		
		Not	Somewhat	Very
Quiet (one on one conversation)	1 2 3 4 5	1	2	3
Television	1 2 3 4 5	1	2	3
Leisure Activities	1 2 3 4 5	1	2	3
Restaurants	1 2 3 4 5	1	2	3
Church	1 2 3 4 5	1	2	3
Meetings/Groups	1 2 3 4 5	1	2	3
Work Place	1 2 3 4 5	1	2	3
Telephone	1 2 3 4 5	1	2	3
Car	1 2 3 4 5	1	2	3
Male Voice	1 2 3 4 5	1	2	3
Female Voice	1 2 3 4 5	1	2	3
Child's Voice	1 2 3 4 5	1	2	3
Other (please indicate) _____	1 2 3 4 5	1	2	3