CORNERSTONE
HEARING CENTER

Legal First Name:_____ M.I._____ Last Name:_____
Preferred Name:_____ Date of Birth: _____ Age:_____
Gender: ____ Male ____Female Today's Date_____
Street Address:_____
City:_____ State:_____ Zip: _____
Home Phone: _____ Cell Phone:_____
Preferred Phone (please circle one): Home Cell Other:_____
Email Address:_____
Emergency Contact Name:_____ Emergency Phone:_____
Emergency Contact Relationship to Patient:_____
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed
Employer:_____ (circle one): Part-time Full-time
Primary Care Physician: _____Phone: _____

How did you hear about us? (Please check all that apply):

_____ Life After 50 _____ Yellow Pages _____ Web-site _____ Physician Referral
_____ Walk-in _____ Friend/Family (whom)_____ _____ Other

MEDICAL INFORMATION

Please list all conditions for which you are being medically treated by a licensed medical provider:

_____

_____

Please list all medications taken regularly: _____

_____

EAR SPECIFIC HISTORY		**If yes, please explain (ie. age, date, which ear) :**
History of ear infections	No	Yes _____
Surgery on your ear	No	Yes _____
Sudden hearing loss	No	Yes _____
Ear difference (one better than other)	No	Yes _____
Tinnitus (ringing/buzzing in ears)	No	Yes _____
Vertigo/Dizziness	No	Yes _____
Ear pain or drainage	No	Yes _____
Family history of hearing loss	No	Yes _____
History of noise exposure	No	Yes _____
History of smoking/drug/alcohol use	No	Yes _____
Chemotherapy/Radiation	No	Yes _____
Head/Neck trauma injury or stroke	No	Yes _____
Prior hearing aid use	No	Yes _____

In which situations do you have difficulty hearing or understanding?

____ One-on-One Conversations ____ Small Groups ____ Outdoors ____ Telephone
____ Religious Services ____ Large Groups ____ Workplace ____ Television
____ Restaurants Other: _____

Primary Insurance(If Tricare, please list sponsor's SS & DOB)

Name of Policy Holder: _____Relationship to Patient:_____
Policy Holder's Birth Date: _____ SS# or ID #: _____
Name of Insurance Provider: _____
Group or Policy #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Insurance Company Phone Number: _____

Secondary Insurance (if applicable)

Name of Policy Holder: _____Relationship to Patient:_____
Policy Holder's Birth Date: _____ SS# or ID #: _____
Name of Insurance Provider: _____
Group or Policy #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Insurance Company Phone Number: _____

What is the reason for your visit today?

Check all that apply:

☐ Difficulty Hearing/ Hearing Loss
☐ Tinnitus/ Buzzing or Ringing in the Ears
☐ Baseline of Hearing
☐ Work-Related Testing
☐ Injury to Ear
☐ Interested in Hearing Aids
☐ Referral to ENT
☐ Other:_____

Please Initial Below:

_____I understand that any procedures not covered by my insurance are my own responsibility.

_____I agree that information provided is true and accurate to the best of my knowledge.

Signature_____ Date_____

Print Name_____ Relationship to Patient_____