



Good Sound Audiology, PLLC

201 W. Guadalupe Rd., Ste. 315, Gilbert AZ 85233

Please print clearly

Date: _____

How did you hear about Good Sound Audiology? _____

What is the reason for today's visit? _____

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Email: _____

SS#: _____ Date of birth: _____ Age _____

Marital status: Please circle: Married Widowed Divorced Single

Spouse name: _____

Responsible party of patient: _____

Relationship to patient: _____

In case of emergency notify _____ Phone _____

Patient employer _____

Employer address _____

Primary physician _____

Physician address _____ Phone _____

Referring physician _____

Would you like us to send a report to your doctor? Please circle: Yes No

Primary insurance _____ Group # _____

Primary insured's name _____ Date of birth _____

Insurance phone _____ ID # _____

I authorize release of any pertinent medical information or test results to my primary physician and/or insurance company.

Patient signature Date

I have been informed that the FDA recommends a medical evaluation of my ears by a medical doctor such as an ENT prior to the purchase of hearing aids.

Patient signature Date



Medical/Audiological History

How is your general health? _____

Recent hospitalizations or surgeries? _____

History of ear disease? _____

Family history of hearing loss? _____

Do you have dizziness, vertigo, or loss of balance? _____

If yes, describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting _____

Do you have tinnitus (ringing, buzzing, hissing)? _____

Which ear? _____ Since when? _____

History of exposure to noise? _____

Have you ever worn a hearing aid? _____ What kind? _____ Size? _____

Were you happy with its performance? _____

Hearing Difficulty Questionnaire

<u>Listening Situations</u>	<u>Hearing Quality</u>					<u>Importance to You</u>		
	Poor			Normal		Not	Somewhat	Very
Quiet (one to 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
Workplace	1	2	3	4	5	1	2	3
Telephone	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 voice	1	2	3	4	5	1	2	3
Other (please indicate)	1	2	3	4	5	1	2	3

Is there any other information you want the Audiologist to know? _____



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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Good Sound Audiology's Notice of Privacy Practices.

Signature of Patient or Guardian

Date

Most patients will benefit from a telecoil or phone program in their hearing aids. Please discuss this with your audiologist.

Our Mission

Good Sound Audiology understands the significant emotional and physical impact that hearing loss can have on one's life. We place strong emphasis on providing quality care that addresses both the physical and emotional concerns of our patients. We strive to provide individualized care in a warm and caring environment. Our goal is to assist each patient in finding solutions to their hearing health concerns.

Thank you for choosing Good Sound Audiology