Webb Hearing Centers – Patient Information Form Today's Date _____

Primary Care Physician _____

○ New Patient ○ Update of Current Patient

Patient Information

Last Name:_____First Name:_____

Marital Status: (circle one) Single / Married / Divorced / Widowed Name of Spouse: (if applicable) _____

Birthdate: ____/____/____ Age:_____Gender: ○ M ○ F Email Address:_____

Street Address:_____

PO Box/Mail: _____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Occupation:_____ Employer:_____

Referred to Clinic by: (circle one) Insurance Plan / Website / Mailer / Yellow Pages / Family or Friend (Name) _____

Insurance Information (please submit your insurance card to office personnel)

Is this patient covered by insurance? (circle one) Y / N Please indicate Primary insurance: (circle one) Aetna HealthNet

Blue Cross/Blue Shield Secure Horizons United Healthcare / PacifiCare Other_____

Subscriber's Name:_____ SSN:_____Birthdate: ___/___/___

Group No:_____ Policy No./ID No._____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other_____

Responsible person for bill:_____Home Address: (if different)_____

_____

We will make a copy of the front and back of your insurance card(s) for our records.

Although every effort is made to obtain accurate benefits information, your insurance company does not guarantee payment.

By signing this document, you (the patient or responsible party) agree to be fully and personally responsible for any unpaid balances. A 1.5% (18% per annum) interest charge may be assessed to delinquent accounts. Your signature also indicates that you have read the information on this sheet and allows our office to release your medical records to insurance companies, physicians or other medical personnel involved with your care. It will serve as a "Signature on File" for insurance claims and must be updated on an annual basis.

Patient/Guardian Signature:_____**Date**:_____

"Thank you for choosing Webb Hearing Centers. We are proud to be your hearing healthcare professionals."

Sun City	Prescott	Sun City West	Chandler	Fountain Hills
10220 W. Bell Rd Ste. 111	1020 Sandretto Dr	14755 W. RH Johnson Blvd Ste. 102	4955 S. Alma School Rd Ste. 11	16605 East Palisades Blvd. Ste 124
Sun City, AZ 85351	Prescott, AZ 86305	Sun City West, AZ 85375	Chandler, AZ 85248	Fountain Hills, AZ 85268
(623)977-0898	(928) 778-5898	(623) 214-5885	(480) 940-1477	(480) 436-7880

Adult Case History

(Please Print)

Patient Name:_____Age:_____Today's Date:_____

Chief Complaint

O Hearing Loss (O Left Ear O Right Ear O Both) O Tinnitus/Ringing O Dizziness
O Difficulty Hearing (O In Quiet O In Noise) O Telephone (O Left Ear O Right Ear)

How long have you noticed this difficulty? _____
Is this problem due to a work-related injury/exposure? (circle one) Yes / No
If so: Date of Injury: _____Explain:_____
Do you feel your hearing is changing? (circle one) Yes / No If Yes (O Gradual O Sudden)
Have you ever been exposed to loud noise, either recently or in the past? (circle one) Yes / No
If so, (mark all that apply)

O Farm Machinery O Music O Hunting/Shooting O Factory Noise
O Power Tools O Military O Jet Engines O Other:_____

Have you seen an Ear, Nose and Throat Physician? (circle one) Yes / No
If so, who did you see?_____When?_____
Have you had surgery that may have affected your hearing? (circle one) Yes / No
Is there a history of hearing loss in your family? (circle one) Yes / No If so, who?_____
Have you ever had an ear infection? (circle one) Yes / No (If yes, O as a child O as an adult)
Have you, in the past 10 years, experienced chronic or acute dizziness, light-headedness or vertigo? (circle one) Yes / No
If yes, please describe:_____

Do you take any prescription medications on a regular basis for any of the following?

O Blood Thinner Medication: _____
O Diabetes Medication:_____
O High Blood Pressure Medication:_____

Please check any of the following that you currently have or have had in the past:

O Arthritis	O Heart Trouble	O Measles	O Parkinson's
O Asthma	O Hepatitis	O Meningitis	O Scarlet Fever
O Bell's Palsy	O High Blood Pressure	O Mumps	O Sinusitis
O Diabetes	O HIV	O Neurological Symptoms	O Stroke/TIA
O Head Injury	O Malaria	O Visual Trouble-Loss/Sight	O MRI Testing

Please rank the following in order of importance if a hearing aid is recommended for you:
(1 most important – 4 least important)

_____ Improved hearing in quiet _____ Improved hearing in noise
_____ Cosmetic appearance _____ Expense

If you are currently using a hearing aid(s), or have in the past, please answer the following:

Which ear is/was aided? (circle one) Right / Left / Both How long have you used a hearing aid(s)?_____

Have you had or do you currently have any of the following? O Chemotherapy within the last 6 months
O Radiation therapy: head/neck area O Bleeding disorder O Chronic ear pain O Contact dermatitis

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