
AUSTIN HEARING SERVICES

6805 N. Capital of Texas Highway, Ste. 265

Austin, Texas 78731

PATIENT NAME: _____

DATE OF BIRTH: _____ **E-MAIL ADDRESS:** _____

CONTACT PHONE # _____ **CELL/WORK #** _____

WHO REFERRED YOU: _____ **PHYSICIAN:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

INSURANCE COMPANY: _____ **PHONE #** _____

SUBSCRIBER OF POLICY: _____ **POLICY #** _____ **GROUP #** _____

1. **REASON FOR THIS VISIT** _____

2. **HAVE YOU HAD ANY PREVIOUS HEARING TESTS?**

a. **WHEN?** _____

b. **WHERE?** _____

c. **RESULTS?** _____

3. **HAVE YOU BEEN EXPOSED TO LOUD NOISES WITH OR WITHOUT HEARING PROTECTION? YES/NO**

4. **DO YOUR EARS PRODUCE A BUILDUP OF CERUMEN (EAR WAX)? YES/NO**

5. **HAVE YOU HAD SURGERY THAT AFFECTED YOUR HEARING OR BALANCE? YES/NO**

6. **IS THERE A FAMILY HISTORY OF HEARING IMPAIRMENT? YES/NO**

7. **DO YOU TAKE PRESCRIPTION OR OVER THE COUNTER MEDICATIONS? YES/NO**

PLEASE LIST: _____

8. **OTHER COMMENTS THAT YOU FEEL MAY BE HELPFUL IN YOUR TREATMENT?**

DATE: _____

I, _____ HAVE RECEIVED A COPY OF AUSTIN HEARING SERVICES' NOTICE OF PRIVACY PRACTICES

I, _____ AM AWARE THAT PROOF OF INSURANCE DOES NOT GUARANTEE PAYMENT BY MY CARRIER. I AM AWARE THAT PATIENTS ARE FULLY RESPONSIBLE FOR THE USUAL AND CUSTOMARY CHARGES FOR TREATMENT AND EQUIPMENT.
