Echo HEARING SYSTEMS & AUDIOLOGY, INC.
Comprehensive personal hearing care you trust.

Name _____ Date of Birth _____

Address_____ City_____Zip Code_____

Phone Number (_____)_____ E-Mail _____

Cell Phone (_____)_____ Occupation_____

Marital Status_____ Spouse's Name (if applicable)_____

So. Sec. No. _____-_____-_____

How did you hear about us? ____Newspaper ____Family ____Friend ____Internet

Do you believe that you have difficulty hearing? ___Yes ___No

If yes, what caused your hearing loss? _____

Do others perceive that you have difficulty hearing? ____Yes ____No
Whom? _____

How long have you noticed a problem? _____

Have you had your hearing tested before? ___Yes ___No If yes, when? _____

Which ear do you use on the phone? ___Left ___Right

Do you now, or have you ever worn hearing aids? ___Yes ___No If yes, how long? _____ Circle:
Right ear only Left ear only Both ears

Would you wear a hearing aid if it helps? ___Yes ___No

Is the size of the hearing aid(s) important to you? ___Yes ___No

Please check any of the following that you have:

___ Pain/Discomfort in ears?
___ History of hearing loss in the family?
___ Diabetic?
___ History of excessive noise exposure?
___ Medical/Surgical history of ears?
___ Sudden hearing loss? (last 30 days)
___ Dizziness?
___ Balance problems?
___ Ringing in your ears?
___ Drainage from the ear(s)?

HIPAA Privacy Protection Notice: Information regarding your health care or status of account will not be released unless your written authorization has been obtained. Echo Hearing Systems & Audiology, Inc. reserves the right to release account balance and billing information to a lawyer or credit bureau should your account become delinquent.

Initials_____

Insurance Information

Do you have hearing aid coverage? ____Yes ____No ____I don't know

If you would like us to verify coverage, please provide the following information:

_____
Name of Insurance Company

_____ _____
Patient Name Cardholder Name (If different than patient)

_____ _____
Patient Date of Birth Cardholder Date of Birth

ID Number _____

Group Number _____

Provider Phone Number _____

Insurance Waiver

If insurance denies payment for a service or supply that is not covered under my health benefit plan, I agree to be personally and fully responsible for payment to Provider. If insurance makes the payment for the amount of a "standard" service or supply and I desire to receive a "deluxe" service or supply, I agree that I am responsible for paying the difference between the Provider's billed charge for the equivalent "standard" equipment/services, and the Provider's billed charge for the "deluxe equipment/services. I understand and agree that I am obligated to pay this amount regardless of whatever amount appears as "member responsibility" on any Explanation of Benefits that I may receive from insurance.

Patient's Signature: _____ Date _____