WISE HEARING

CUSTOM HEARING SOLUTIONS

www.wisehearing.com

Confidential Patient Information

Date: _____

Last Name: _____ First Name: _____

DOB: _____Phone – Cell: _____ Home:_____

Address:_____ City:_____State:_____ Zip Code:_____

Email: _____

Insurance Company: _____ ID:_____ Group#: _____

Primary Care Physician:

_____

The following questions are designed to help us to evaluate your hearing health.

1- Have you ever consulted an ENT? Yes ☐ No ☐ if yes, please explain:

_____

2- Have you ever been exposed to a loud noise? Yes ☐ No ☐

3- Does anyone in your family have a hearing problem? Yes ☐ No ☐

4- Do you have difficulty understanding speech in group conversations? Yes ☐ No ☐

Noisy places? Yes ☐ No ☐ , watching TV? Yes ☐ No ☐ , on the phone? Yes ☐ No ☐

5- Do you currently wear hearing aids? Yes ☐ No ☐

If you need hearing aids, would you accept our recommendation? Yes ☐ No ☐

_____

Thank you

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☐ KEARNY
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