BEST Hearing Aid Solutions
We make house calls
In home, In office ...In Style

Patient's Name: _____

Address: _____
Street **City** **State** **Zip**

Date of Birth: ___ / ___ /____ **Phone:** _____ **Referred by:** _____
Mth / Dt / Yr

Email Address: _____

HIPAA Acknowledgement

I acknowledge that the Notice of Health Information Privacy Practices has been made available to me (on company website or in office upon request).

_____
Signature of Patient or Patient's Legal Representatives

Listening Needs and Lifestyle Assessment

What is most important to you? Use rating of 1 to 5 1 is the least important; 5 is the most important

Sound Quality & Clarity of Speech_____ Automatic/Self-Adjusting_____ Cost_____ Appearance_____ iPhone/iPad Connectivity_____

Please circle the response that best describes your listening and lifestyle needs:

Circle One: Without hearing aids - OR - With my current hearing aids.

Situation	Seldom	Occasional	Frequent
♦ I am active throughout the day and cannot understand what people are saying.	1	2	3
♦ Noisy restaurant dining and attending large parties make it challenging to hear.	1	2	3
♦ It is challenging to understand the discussions in social and work meetings.	1	2	3
♦ I spend time in small group settings and have trouble following the conversations.	1	2	3
♦ Understanding TV/movie dialogue is frustrating, and I turn the volume up.	1	2	3
♦ I cannot understand what people say on personal and work related phone calls.	1	2	3