Peninsula HEARING SERVICES

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Ph 650.373.2081 • Fax 650.373.2002
www.earsandhearing.net

INTAKE FORM

DATE:_____

PERSONAL INFORMATION

Client Name	First	Last		
Mailing Address	Address	City	State	Zip Code
Telephone:		**Email (if used):**		
Birthdate:	**Circle:** Male Female	**Last 4 digits of Social Security #:** ___ ___ ___ ___		
Referring Physician: First:	Last:	City		
Do you have a conservator, guardian or other trustee responsible for your financial affairs? Yes No (if yes, please state that person's name and contact information below)				
First and Last Name	Relationship to Client	Address and Telephone		

APPOINTMENT CANCELLATIONS

Peninsula Hearing Services asks that you contact the office no less than 24 hours in advance to reschedule or cancel an appointment. Our policy is to reserve the right to assess **a $65 charge** for missed appointments or late cancellations.

PLEASE INITIAL: _____

INSURANCE COVERAGE

Peninsula Hearing Services will file a claim on your behalf for services rendered if you present with health insurance. You authorize release of information to your insurance company for claims billing purposes. You acknowledge that should your health insurance later determine the services are not within the scope of benefits and/or are non-covered or deny part or all of that claim, you agree to be personally and fully responsible for payment of that claim within 60 days of services provided.

PLEASE INITIAL: _____

COPY OF HEARING EXAM

You may request a copy of your hearing exam at the end of your visit at no charge. Should you request a copy following your appointment, our office reserves the right to assess a **$25 administrative charge** to process and then mail/fax another copy for your benefit.

PLEASE INITIAL: _____

Please complete the BACK page

Ear, Hearing & Balance CONCERNS

1. I suspect hearing impairment ☐ Yes ☐ No
2. If suspected hearing impairment, which ear(s)? ☐ Right ☐ Left ☐ Both
3. I have visited a physician for an ear/hearing concern in the last 90 days? ☐ Yes ☐ No
4. I have worn or am currently wearing hearing a device(s)? ☐ Yes ☐ No

Ear, Hearing & Balance MEDICAL HISTORY

Balance, vertigo or dizziness concern that first started in the last 90 days? ☐ Yes ☐ No
Pain or discomfort in ears that first started in the last 90 days? ☐ Yes ☐ No
Active ear drainage that first started in the last 90 days? ☐ Yes ☐ No
Sudden hearing loss that first started in the last 90 days? ☐ Yes ☐ No
History of exposure to loud/excessive noise? ☐ Yes ☐ No
Is there a family history of hearing loss? ☐ Yes ☐ No
Ringing, buzzing, noise in ear(s)? ☐ Yes ☐ No Which ear(s)? ☐ Right ☐ Left ☐ Both
Ear feels plugged or full? ☐ Yes ☐ No Which ear(s)? ☐ Right ☐ Left ☐ Both

Please add any additional information you feel is important

_____

_____

_____

DO NOT COMPLETE-Practitioner Notes

Physician/Referral: Provider Reviewed Form:

Primary Complaint: _____

_____

Onset: _____

Notes:_____

_____

_____

Interpreter used? Yes No Name & Relationship: