EARON HEARING CLINIC
WHERE HEARING IS UNDERSTANDING

Aksun Hearing Clinic is now
EarOn Hearing Clinic

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North Palm Beach, FL 33408

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Phone # (561) 341-0229

Hearing Health Report (please print clearly)

First Name _____ MI _____ Last Name _____

Birthdate _____ Age _____ Gender ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Phone _____ Alt Phone _____

Email _____

Marital Status ☐ Single ☐ Divorced ☐ Widow(er) ☐ Married Name of Spouse _____

Name of Observing Party _____ Relationship _____

Past or Present Occupation _____

Reason for your visit today _____

Insurance Information (please present your insurance card(s) to the receptionist.)

Primary Insurance _____ ID # _____

Secondary Insurance _____ ID # _____

Primary Physician's Name & Phon _____

How did you hear about us?

☐ Friend/Family Name _____ ☐ Physician _____

☐ Newspaper ☐ Website ☐ Seminar ☐ Assisted Living Center _____

☐ Expo _____ ☐ Other _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

List any current medications being taken _____

Check all that apply: ☐ Vision Difficulty ☐ Pacemaker ☐ Blood thinner use ☐ Thyroid Problems
☐ High Blood Pressure ☐ Diabetes If yes, Insulin dependent? ☐ Yes ☐ No

Medical conditions that you would like us to be aware of: _____

Hearing History

Do you have ringing in the ear / head noises? ☐ Yes ☐ No

If yes, ☐ Not Bothersome ☐ Trouble Falling Asleep ☐ Difficult to Concentrate ☐ Interferes With Social Life

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No

If yes, when? _____ Physician/ENT: _____

When/where was your last hearing test? _____

Have you ever experienced vertigo, spinning dizziness or have a history of falling down? ☐ Yes ☐ No

If yes, Please give details _____

Do you have a history of ear infections, drainage from ears, excessive cerumen (wax) or ear pain? ☐ Yes ☐ No

If yes, Please give details _____

Have you experienced sudden or rapid hearing loss with in last 90 days ☐ Yes ☐ No _____

If yes, Please give details _____

Have you ever been fit with hearing aids? ☐ Yes ☐ No How Long? _____ Do you wear daily? ☐ Yes ☐ No

#1 dissatisfaction with your current hearing aids? _____

Consent for Treatment

On behalf of myself or my dependents, if I choose to order ear molds, ear protection, in the ear hearing instruments or have them repaired, I hereby authorize the relevant procedures to be performed, possibly including the insertion of silicone or similar material into the ear canal to obtain ear impressions. I understand that the cerumen removal process and or the impression taking of my ears are a simi-invasive procedure and that there is always the possibility of trauma to the skin in my ear canal or tympanic membrane and ear infection. For deep canal impressions, the procedure may be somewhat uncomfortable, but may be necessary for the effectiveness of the recommended hearing instrument. Small abrasions and slight bleeding are not uncommon. Otoscopic inspection of my ear will be performed before and after the procedure. The hearing professional will use accepted procedure to avoid adverse results. In the event of uncommon abrasions or trauma, I will be referred back to my PCP or an ENT for treatment. I, the undersigned patient, hereby acknowledge that I have read and understand the important notice printed above. I understand that no gurantee has been made to me as to the results. I recognize the risks of receiving the procedure(s) described. I hereby consent to the procedure(s). I authorize EarOn Hearing Clinic to release my Protected Health Information (PHI) to the physician(s) deemed appropriate by AHC with the goal of enhancing the progress of my hearing healthcare. Further, they may receive said PHI from said physicians.

Patient Signature: _____ Today's Date _____

Office Use Only: Notes:

DB #:

SD ☐ PB ☐