SOUND ADVICE

Musician Patient Information Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Physician: _____ Phone #: _____

Physician's Address: _____

Primary Insurance Company: _____ Policy ID #: _____

Whom may we thank for referring you to our office? _____

Reason for Visit: _____

Family history of hearing loss: _____ History of ear infections: _____

Type of work: _____ Name of band: _____

Instruments you play: _____ Years played each instrument: _____

Hours played per week: _____ Type of hearing protection you wear: _____

Where do you stand/sit in relation to other musicians? _____

Do your ears ring after a performance or rehearsal? _____

Any other symptoms? _____

Do you feel you play: ☐ Not too loud ☐ Loud enough ☐ Too loud

Do you wear studio phones or personal stereo phones? _____

How many hours has it been since you were exposed to loud sounds? _____

Have you worked or do you work in a noisy environment? _____

If so, for how long? _____

Do you participate in any of the following? _____

☐ Ride a motorcycle How long? _____ Hearing protection used? _____

☐ Exposed to gunfire How long? _____ Hearing protection used? _____

☐ Use power tools How long? _____ Hearing protection used? _____

Do you take aspirin? _____ If so, how many per week of what strength? _____

Do you have any of the following conditions? Please check all that apply.

☐ Hearing Loss
☐ Diabetes
☐ Kidney Disease
☐ High Blood Pressure
☐ Heart Disease
☐ Dizziness
☐ Stroke
☐ Other _____

Patient Medical History Form

Patient Name: _____

Please answer the following:

Have you ever had your hearing tested? ☐ Yes ☐ No

Do you hear ringing or noises in your ear? ☐ Yes ☐ No

Have you had recent earaches, ear infections or ear discharge? ☐ Yes ☐ No

Do other members of your family have hearing problems? ☐ Yes ☐ No

Do you have dizzy spells or nausea? ☐ Yes ☐ No

Have you been or are you currently exposed to high levels of noise? ☐ Yes ☐ No

Do you feel as though you have hearing loss? ☐ Yes ☐ No

If yes, when did you first notice your hearing loss? _____

If yes, did your hearing loss progress gradually? ☐ Yes ☐ No

Do you wear hearing instruments? ☐ Yes ☐ No

If yes, for how long? _____

Have you ever seen an ENT (ear doctor)? ☐ Yes ☐ No

Have you ever undergone surgery on your ear(s)? ☐ Yes ☐ No

Are you being treated for any health concern(s)? ☐ Yes ☐ No

If yes, please list: _____

_____

Are you taking any medication(s)? ☐ Yes ☐ No

If yes, please list: _____

_____

Insurance Alert

I, _____ , acknowledge that Sound Advice has contacted my health insurance company as a courtesy.

Benefits that are quoted for audiologic services or hearing instruments rendered at this office **do not** guarantee payment. Sound Advice shall not be held liable for inaccurate information quoted by my insurance carrier or deductibles that have yet to be met by the insured person.

We strongly urge our patients to obtain the exact and maximum benefit allowable in writing by their current health care plan. This is invaluable should any questions arise.

Please understand that we strive to provide you with the best services possible. We will be happy to bill your health carrier for our services; however, we cannot represent you should your health coverage fail to complete the verbally quoted reimbursement amount.

Signature of Insured: _____ Date: _____