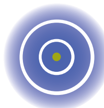

Amplify Your Life.
Woodard Hearing Centers

Date of Call: ____________________

Office: ____________ Serviced By: ____________
Day: ________ Time: ________ Date: ________

PATIENT INFORMATION

Patient Name: ______________________________ Birthdate: ____________

Permanent Address: ______________________________

City: ____________________ State: ____________ Zip: ____________

Telephone: ____________________ Alternate Phone: ____________________

Work/Cell Telephone: ____________________ Alternate Phone: ____________________

Who will be Accompanying You?: ____________________ Relationship?: ____________

HOW DID YOU HEAR ABOUT US?

- ❍ Newspaper
- ❍ Radio Ad
- ❍ Television Ad
- ❍ Phone Book
- ❍ Website/Internet
- ❍ Received a Letter
- ❍ Friend/Family Referred (Name) ____________________
- ❍ Doctor Referral (Name) ____________________
- ❍ Other (Please explain) ____________________

ADDITIONAL INFORMATION

Seasonal Address: ____________________ City: ____________ State: ________ Zip: ________

(Occasionally we send out important news/information to our patients. Please include your email-address below:)

E-Mail Address: ______________________________

PHYSICIAN INFORMATION

Name of Family Physician or ENT: ______________________________

Address: ____________________ City: ____________ State: ________ Zip: ________

HEARING HEALTH HISTORY

HEARING HEALTH HISTORY	Yes	No	If Yes, Please List/Describe:
Do you ever notice its difficult to understand words clearly?			
Do you have trouble hearing women/children?			
Do people say you have the TV or radio turned up?			
Do you ask people to repeat themselves?			
Do you sometimes feel that people are talking “softly” or mumble?			
Do you have difficulty hearing speech in background noise?			

On a scale from 1-10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability? (circle one) 1 2 3 4 5 6 7 8 9 10

AUTHORIZATIONS

Authorization to Release Information: I hereby authorize the release of any information necessary in the course of my testing, treatment or processing of claim including a report of any evaluation in this office to be sent to my physician listed above.
Trial Period: Woodard Hearing Centers offer a 60 day trial period upon which time a full refund will be honored less the professional services fee and any custom ear mold charges.
Responsibility for Payment: I understand that I am personally responsible for full payment which is due at the time of hearing aid fitting. If an insurance claim is filed by Woodard Hearing Centers on behalf of the patient, patient portion of insurance reimbursement will be refunded to the patient upon receipt.

Signature: ______________________________ Date: ____________

TO BE COMPLETED BY AUDIOLOGIST/DISPENSER

Accompanied by: ____________________ Relationship to Patient: ____________________

Tested Before? ____________ When? ____________ Where? ____________ Findings: ____________

Possible Cause of Hearing Loss? ______________________________

Past Medical Treatment/Surgery on ear/s? ____________ When? ____________ Where? ____________

Previous User: Yes/No

How Long? ____________

	Mfgr:	Model:	Serial #	Aid Type:	Battery:	Yr. Purch:	Purchased From:
R							
L							

Comments: ______________________________

Patient Prospect File | HL Code: A B C D R F H S | Bnrl Pros Y N | Send NL Y N | Ofc: