Ascent
AUDIOLOGY & HEARING

2569 Cowan Blvd. • Fredericksburg, VA 22401
PHONE (540) 373-6797 • **FAX** (540) 373-6973
www.AscentAudiologyFredericksburg.com

Confidential Client Information

1 Patient Information

Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Primary Insurance: _____ Insured Name: _____ DOB: _____

Secondary Insurance: _____ Insured Name: _____ DOB: _____

How did you hear about us? ☐Patient ☐Newspaper ☐Direct Mail ☐Community Event ☐Physician Referral ☐Website

2 Medical History

Have you seen a doctor specializing in diseases of the ear?: ☐ Yes ☐ No

Please give doctor's name and date seen: _____

Name of Primary Care or Referring Physician: _____

Physician's telephone number: _____ Fax: _____

Have you ever had ear surgery: ☐ Yes ☐ No By whom: _____

Have you ever had your hearing tested: ☐ Yes ☐ No By whom: _____

Is there diabetes in your family?: ☐ Yes ☐ No How many prescription drugs do you take daily? _____

Are you taking blood thinners?: ☐ Yes ☐ No Do you wear a pacemaker?: ☐ Yes ☐ No

3 About Your Hearing

☐Yes ☐No Do you have a deformity of the ear?

☐Yes ☐No Do you have any pain in your ears?

☐Yes ☐No Sudden or rapid hearing loss in the past 90 days?

☐Yes ☐No Sudden or long-term dizziness?

☐Yes ☐No Hearing loss in one ear in the last 90 days?

☐Yes ☐No Have you notice a ringing in your ears?

☐Yes ☐No Drainage from either ear in the past 90 days?

Which is your poorer ear?

☐Right ☐Left ☐ Same

Does anyone else in your family have a hearing problem? ☐Yes ☐No Who? _____

In what environment does your hearing problem give you the most trouble? _____

4 Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my:
☐Right ear ☐Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete backside →

5 Hearing Needs Assessment

Put a "1" before the one thing that is most important to you in purchasing a hearing aid.
Now put a "2" before the second most important thing to you when purchasing a hearing aid.
Next, put a "3" before the third most important thing to you when purchasing a hearing aid.
Lastly, put a "4" before the least important thing to you when purchasing a hearing aid.
(Remember to use a 1 , 2 , 3 and a 4.)
These are your choices:

_____Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____ Appearance

6 Motivation

What motivated you to come in today?_____

_____

_____

7 Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated . . . . . **Very Motivated**

8 Self Questionnaire

Please answer "yes, "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

9 Acknowledgment of Notice of Privacy Practices

☐ By checking this box and signing below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I have read, understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

Signature of Patient or Guarantor: _____ Date:

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Please Answer the following questions by checking the appropriate response:

	Yes	Sometimes	No
1. I have a problem hearing over the telephone.....	☐	☐	☐
2. I have trouble following the coversation when two or more people are talking.....	☐	☐	☐
3. People complain that I turn the TV volume too high.....	☐	☐	☐
4. I have to strain to hear conversations.....	☐	☐	☐
5. I miss hearing some common sounds like the phone or doorbell.....	☐	☐	☐
6. I have trouble hearing conversations in a noisy background.....	☐	☐	☐
7. I misunderstand some words in a sentence and need to ask people to repeat themselves.....	☐	☐	☐
8. I have trouble understanding women and children.....	☐	☐	☐
9. I have worked in noisy environments.....	☐	☐	☐
10. People seem to mumble.....	☐	☐	☐
11. People get annoyed because I misunderstand what they say.....	☐	☐	☐
12. I misunderstand what others are saying and make inappropriate remarks.....	☐	☐	☐
13. I avoid social activities because I cannot hear well and fear that I'll reply improperly.....	☐	☐	☐

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Cerumen Removal Consent Form

Dr. Paul Kuster may decide it would be best to remove ear wax from your ear canal. Removing ear wax is something that should be done by a professional. It is not without risk. Certain risk factors may make it more likely for you to incur complications such as bleeding and irritation. These complications may occur even if you have no risk factors but these complications are not life threatening. The process of wax removal can involve discomfort, bleeding, hearing loss and tinnitus. If you decide you do not want to have your wax removed at any time, you may stop the procedure.

By Signing this form of consent, you are agreeing to release Ascent Audiology & Hearing - Fredericksburg it's owners, officers, directors, employees and representatives from any complications arising from the removal of ear wax from your ear canal as explained above, You represent and warrant that you have the right, power, legal capacity and requisite authority to enter into this consent and release and will sign any additional documents to make its provisions fully effective. You acknowledge that you have read and voluntarily enter into this consent and release and understand its meaning and acknowledge that it is binding upon you, your legal representative, heirs, and assigns.

_____ _____

Signature Date