CENTRAL ILLINOIS HEARING, LTD.

Name:_____ **Nickname**: _____ **Date of Birth**: _____

Please list your Phone #, then check which # you prefer to be contacted: **Age**: _____

□ **Home**: _____ □ **Work:** _____ □ **Cell:** _____

Are we allowed to leave a descriptive message on the phone numbers provided ■ **YES** □ **NO**

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

E-mail: _____ **Marital Status:** _____ **Gender:** _____

Primary Physician: _____ **Referring Physician:** _____

Emergency Contact and Phone #_____

Insurance Information: (we will also copy insurance cards at your appointment)

Primary Insurance:_____ **Member ID#** _____ **Group #** _____
Subscriber Name: (if not the same as patient) _____ DOB: _____

Secondary Insurance:_____**Member ID#** _____ **Group #** _____
Subscriber Name: (if not the same as patient) _____ DOB: _____

Have you experienced or been diagnosed or treated for: (mark the box)

□ Hearing Loss
- □ Right Ear □ Left ear □ Both ears
- □ Gradual □ Sudden □ Fluctuating

□ Currently wear a hearing device
□ Interested in a hearing device
□ Hear noises/ringing in your ears/head
- □ Right ear □ Left ear □ Both ears
- □ Constantly □ Occasionally □ Rarely

□ Exposure to loud noises
□ Ear Pain
□ Ear Drainage
□ Ear wax buildup
□ Fullness or stuffiness in your ears
□ Facial numbness
□ Facial weakness
□ Facial tingling
□ Dizziness
□ Dizziness with nausea
□ Dizziness with vomiting
□ Dizziness with noises in your ears
□ Unsteadiness
□ Off balance / falls
□ Ear Surgery
□ Depression
□ Anxiety
□ Diabetes
□ Taking blood thinners
□ Sinusitis
□ Family history of hearing loss

Explanations can be written can on back side of this sheet, if needed

List Current Medications or vitamins: (Or provide list) _____
_____

_____ _____
Signature of Patient or Legally Responsible Person Date