

**Audiology Center of Yardley, LLC  
Synergy Hearing**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient: \_\_\_\_\_  
**First Name                      Middle Initial                      Last Name**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: F \_\_\_\_ M \_\_\_\_ Email: \_\_\_\_\_

Personal Contact in Case of Emergency: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

**\*If patient is a minor, please complete the following section:**

**\*Responsible Party:** \_\_\_\_\_

**\*Name and address of Employer:** \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*  
**PLEASE GIVE INSURANCE CARD(S) TO SECRETARY FOR COPYING**  
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**Assignment of Insurance Benefits**

The undersigned authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this consent authorizes Audiology Center of Yardley L.L.C. to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

The undersigned further authorizes the above named insurance company/ies to pay directly to Audiology Center of Yardley L.L.C., all benefits, if any, otherwise payable for its services as described on any submitted claim or invoice. In the event my insurance does not pay for such services, I understand that I am financially responsible for all charges incurred.

\_\_\_\_\_  
Signature of Insured or Authorized Party                      Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**About your ears:** Do you have any of these symptoms?

- Yes No Deformity of the ear
- Yes No Drainage from the ear
- Yes No Sudden or rapid loss of hearing in the past 90 days
- Yes No Acute or chronic dizziness
- Yes No Have you fallen in the past year?  
If yes, date(s) \_\_\_\_\_
- Yes No Have you seen a doctor for wax removal?
- Yes No Do you ever have pain in your ears?
- Yes No Do you ever notice tinnitus (ringing, buzzing, roaring) in your ears?
- Yes No Have you been exposed to excessive loud noise? (loud work environment or excessive recreational noise?)  
Which is your poorer ear?      Same    Right    Left
- Yes No Have you seen a doctor specializing in diseases of the ear?  
If yes, date \_\_\_\_\_
- Yes No Have you had your hearing tested?  
If yes, date \_\_\_\_\_ by whom \_\_\_\_\_
- Yes No Have you ever had any type of ear surgery?  
If yes, type of surgery \_\_\_\_\_ by whom \_\_\_\_\_

**About your hearing:** Do you experience difficulty with the following?

- Yes No Understanding conversation
- Yes No Hearing in a crowd
- Yes No Hearing by telephone
- Yes No Hearing in a restaurant
- Yes No Hearing TV
- How long have you had a hearing problem? \_\_\_\_\_
- Yes No Does anyone else in your family have a hearing problem?  
What relationship? \_\_\_\_\_
- Yes No Do you now or have you ever worn a hearing aid? If yes, what would you like to improve about it? \_\_\_\_\_

List any medications (including non-prescriptions) you are currently taking (dosage/frequency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes    No

Please rank the following items on a scale of 1- 4 in terms of importance to you when purchasing a hearing device. (1 = Most Important 2 = Important 3 = Somewhat Important 4 = Least Important) Use each number only *once*.  
\_\_\_\_ Sound Quality & Clarity    \_\_\_\_ Durability/Reliability    \_\_\_\_ Cost    \_\_\_\_ Appearance

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially) regarding doing something about your hearing loss? (please circle one)  
not motivated    1    2    3    4    5    6    7    8    9    10    very motivated



**Acknowledgment of Receipt of Notice**

I hereby acknowledge that I have read this medical practices' Notice of Privacy Practices.

Yes \_\_\_\_\_ No \_\_\_\_\_ I wish to receive a copy of the Notice of Privacy Practices

Signed \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient indicate relationship

- \_\_\_\_\_ Parent or guardian, if patient is a minor
- \_\_\_\_\_ Guardian or conservator of an incompetent patient
- \_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of patient \_\_\_\_\_

For office use only:

Signed and received by \_\_\_\_\_

Acknowledgment refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_