

# Sophisticated Hearing LLC

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

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

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

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Occupation (Past or Present)? \_\_\_\_\_

Date of Birth \_\_\_\_\_

Marital Status: Single Married Widowed Name of Spouse: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

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

Physicians Phone # \_\_\_\_\_

May we send a Copy of Today's results to your Doctor listed above? YES NO

Have you had your hearing tested before? \_\_\_\_\_ When? \_\_\_\_\_  
Where? \_\_\_\_\_

Have you ever seen an ear doctor before? \_\_\_\_\_ When? \_\_\_\_\_

Name of Ear Doctor \_\_\_\_\_

Reason/Outcome \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| • Do you experience pain or discomfort in your ears?        | YES | NO |
| • Do you experience ringing in the ears?                    | YES | NO |
| • History of sudden/rapid hearing loss in the past 90 days? | YES | NO |
| • Have you ever had ear surgery?                            | YES | NO |
| • Has your hearing changed in the past 90 days?             | YES | NO |
| • Do you have any fluid or drainage from the ear?           | YES | NO |
| • Do you experience sudden or long term dizziness?          | YES | NO |
| • Have you avoided conversation because of your hearing?    | YES | NO |
| • Have you ever seen a doctor for ear wax removal?          | YES | NO |
| • Are you currently taking any Medications?                 | YES | NO |

○ If YES was selected above, please list all medications:

\_\_\_\_\_

How long have you had a problem hearing or understanding? \_\_\_\_\_

Which ear do you have the most difficulty with? Right Left Both

Which ear do you use on the telephone? Right Left Both

Do you currently wear a hearing aid? YES NO Right Left Both

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What Brand or Manufacturer? \_\_\_\_\_

Model: \_\_\_\_\_ Year Purchased: \_\_\_\_\_

Where do you notice difficulty hearing or understanding speech? \_\_\_\_\_  
\_\_\_\_\_

If there is a problem are you willing to accept help? YES NO

How did you hear about Sophisticated Hearing? Please choose from options below: (Circle below and add details if available)

- YELP
- Google
- Newspaper Ad: Which Newspaper? \_\_\_\_\_
- Magazine Ad: Which Magazine? \_\_\_\_\_
- Sophisticated Hearing Website
- Direct Mail
- Friend or Family Member: Who referred you to us? \_\_\_\_\_
- Dr's Office: Please provide name of referring Dr. \_\_\_\_\_
- Insurance Provider: Which provider? \_\_\_\_\_
- Angies List
- Health Fair? Where was the Health Fair held? \_\_\_\_\_
- Hearing Care Presentation? Where? \_\_\_\_\_
- OTHER: Please provide details: \_\_\_\_\_

What is your preferred Method of Communication with Dr. Ann Marie Olson (Please Circle all that apply:

- Call my Home Phone
- Call my Cell Phone
- Text my Cell Phone
- Email me
- Regular Mail

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Hearing Acuity Assessment

Name \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_ Score \_\_\_\_\_

Please answer the following questions by checking the appropriate response:

	Yes	Sometimes	No
1. Does a hearing problem cause you to have difficulty understanding in group situations? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does a hearing problem cause you to ask people to repeat what they have said? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty hearing when someone speaks in a whisper?* .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does a hearing problem cause you to ask people to speak louder or move closer to you? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does a hearing problem cause you difficulty when listening to the TV or radio?* .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?* .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does a hearing problem cause you to avoid situations or activities more often than you would like? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does a hearing problem cause you to have difficulty on the telephone? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?* .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?* .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*Adapted from HHIE

# Sophisticated Hearing LLC

50 N. Franklin Tpke, Suite B1, Ho-Ho-Kus, NJ 07423 (201)-445-2455

1. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Yes

No

2. I authorize Sophisticated Hearing LLC to electronically share my audiological records, including hearing thresholds and hearing aid information if applicable, with my associated Health Insurance provider, Hearing Aid Manufacturer and my Physician indicated below.

Yes

No

Physician Name: \_\_\_\_\_

Physician Contact Information: \_\_\_\_\_

3. Do you allow Sophisticated Hearing to communicate with you via email?

You may receive information about annual hearing tests, services and/or office promotions.

Yes

No

Email address to send correspondence to: \_\_\_\_\_

4. Do you allow Sophisticated Hearing to mail periodic Check Up reminders or promotions to your home?

Yes

No

5. Please list telephone numbers we may contact you and leave a message if necessary.

HOME: \_\_\_\_\_

CELL: \_\_\_\_\_

WORK: \_\_\_\_\_

You may stop authorization of electronic communication at any time by contacting the office of Sophisticated Hearing at 201-445-2455 or via email at: [info@sophisticatedhearing.com](mailto:info@sophisticatedhearing.com)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name