BRAGG FAMILY
HEARING
AID CENTERS
Quality and service you can "Bragg" about!

Welcome to Bragg Family Hearing Aid Centers. We want to provide you with excellent hearing healthcare. Please tell us a little bit about yourself by completing as much as possible.

Today's Date: ___/___/____

Patient's Personal Information:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed

Name: _____ Date of Birth: ___/___/____
Last First Middle In.

Mailing Address: _____
Street City State Zip

Home Phone: (___)_____Work Phone: (___)_____Cell Phone: (___)_____

Email Address: _____ Occupation (If Applicable): _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact Information: _____
Name Phone Relationship

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐Retired ☐ Active Military ☐ Not Employed

How Did You Hear About Us? :

☐ Mail ☐ Newspaper ☐ Yellow Pages ☐ Health Fair ☐ Internet ☐ Physician ☐ Health Plan

☐ Vocational Rehab ☐ Seminar ☐ Friend/Co-worker ☐ Family Member ☐ Other:_____

If Someone Referred You, Please Provide Their Name So We May Thank Them: _____

Insurance Information: Please Present Driver's License & Insurance Cards to Receptionist

PRIMARY Insurance Name: _____ Phone: _____

Address: _____
Street City State Zip

Name of Policy Holder: _____ Date of Birth: ___/___/____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐Child ☐ Other: _____

Policy/ID #: _____ Group #: _____ Hearing Healthcare Benefit: _____

SECONDARY Insurance Name: _____ Phone: _____

Address: _____
Street City State Zip

Name of Policy Holder: _____ Date of Birth: ___/___/____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐Child ☐ Other: _____

Policy/ID #: _____ Group #: _____ Hearing Healthcare Benefit: _____

Patient's Personal Information:

We are committed to our patient's right to privacy. All information regarding your condition, diagnosis or treatment is strictly confidential and will only be released with your written consent to your primary care physician, family, friends, employers, attorneys or insurance companies. According to federal law, we are required to make available to you a copy of our privacy practices. Your signature below acknowledges your receipt of such:

Patient Signature: _____ Date: _____

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our initial findings at your request. Please Initial ONE below:

_____(initial) YES, I authorize a copy of my results to be sent to my physician
_____(initial) NO, I do not authorize a copy of my results to be sent to my physician

Medical History:

Please list all medications you are currently taking (You may provide a list to the receptionist):

_____

_____

Do you have any family history of hearing loss?: ☐ Yes ☐ No If so, who? : _____

Do you have any pain or discomfort in your ear? : ☐ Left ☐ Right ☐ Both ☐ None

Do you have in drainage in your ear within the past 90 days? : ☐ Left ☐ Right ☐ Both ☐ None

Any sudden or progressive hearing loss in the past 90 days? : ☐ Left ☐ Right ☐ Both ☐ None

Do you have a history of ear infections? : ☐ Left ☐ Right ☐ Both ☐ None

Do you have ringing or other noises in your ear? : ☐ Left ☐ Right ☐ Both ☐ None

If so, how often? : ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly For how long? : _____

Do you experience any dizziness or vertigo? ☐ Left ☐ Right ☐ Both ☐ None

If so, how often? : ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly For how long? : _____

Have you ever had ear surgery?: ☐ Yes ☐ No If yes, when?: _____ Physician: _____

Additional information about treatment: _____

Have you seen your physician regarding any of the above conditions? : ☐ Yes ☐ No

Additional information about treatment: _____

Do you know what caused your hearing loss? ☐ Yes ☐ No If so, please specify:_____

Have you previously had a hearing test? : ☐ Yes ☐ No If so, when? : _____

Amplification History (If Applicable):

Have you previously worn hearing aids? ☐ Yes ☐ No

Do you currently wear hearing aids? ☐ Yes ☐ No

Current Hearing Aids:

Left Ear: Make: _____Model: _____Date Fitted (Mo/Yr): _____/_____

Right Ear: Make: _____Model: _____Date Fitted (Mo/Yr): _____/_____

If you could improve something about your current instruments, what would it be? :

_____

_____

Hearing Handicap Inventory:

In the following questions, think about your experiences in each of the following situations **without** the use of hearing aids if you do not wear them or **with** the use of hearing aids if you currently do. Check the most appropriate answer. Please do not leave any blank.

Situation	**YES**	**SOMETIMES**	**NEVER**
I have a problem hearing over the telephone…			
I have trouble understanding things on TV or have been told I turn the TV up too loud…			
I sometimes have to strain to understand conversations…			
I have to worry about missing a telephone or doorbell…			
I have trouble hearing conversations in a noisy background such as a crowded room or restaurant…			
I have arguments with friends or family members because I did not hear or understand them…			
I have to ask others to repeat themselves…			
I believe many people that I speak to mumble (or don't speak clearly)…			
I misunderstand what others say and respond incorrectly…			
I avoid social activities because I cannot hear well …			
Family members and friends have told me they think I may have a hearing loss…			

Please rate the follow hearing instrument features by level of importance

	Most Important	Very Important	Somewhat Important	Not Very Important
Clarity				
Size				
Cost				
Adjustability				
Comfort				

Do you believe you have a hearing loss? : ☐ Yes ☐ No ☐ Maybe

Would you wear a hearing aid if it helped? : ☐ Yes ☐ No ☐ Maybe

What (or who) has encouraged you NOW to make a positive decision about your hearing? :

_____