Luebbe Hearing Services

Personal History

a member of AUDIGY GROUP

Today's Date _____

Name _____ Date of Birth _____

Address _____ City _____ Zip Code _____

Phone Number _____ _____ _____ Email Address and Permission to Email: _____ Yes ☐ No ☐

Cell Phone _____ _____ _____ Social Security Number _____ _____ _____

Employment Status Employed Unemployed Retired Occupation _____

Marital Status (circle) M S W Spouse's Name (if applicable) _____

Emergency Contact Name & Relationship _____ Number _____ _____ _____

Family Doctor Name _____ Phone _____ _____ _____ Location _____

Referring Doctor Name _____ Phone _____ _____ _____ Location _____

Reason for Appointment: _____

Hearing Health Information

Do you believe that you have difficulty hearing? (circle) Yes No

If yes, what caused your hearing loss? _____

Do others perceive that you have difficulty hearing? (circle) Yes No

If yes, whom? _____

How long have you noticed a problem hearing? (circle) 5 years or less 5-10 years 10+ years

Have you had your hearing tested before? Yes No If yes, when and where? _____

Which ear do you use on the phone? (circle) Left Right

Do you now, or have you ever worn hearing aids? (circle) Yes No If yes, how long? _____

(circle) Left ear only Right ear only Both ears

Would you wear a hearing aid if it helps? (circle) Yes No

Is the size of the hearing aid(s) important to you? Yes No

What do you like about your (current) hearing aids? _____

What would you like changed? _____

Please check any of the following that you have:

____ Pain/Discomfort in ears? (last 30 days)

____ History of hearing loss in the family?

____ Diabetic?

____ History of excessive noise exposure?

____ Medical/Surgical history of ears?

____ Sudden hearing loss? (last 30 days)

____ Dizziness?

____ Balance problems?

____ Ringing in your ears?

____ Drainage from the ear(s)? (last 90 days)

If anything is marked yes, please explain: _____

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How did you hear about us? (check any that apply)

☐ Mail ☐ Newspaper Ad ☐ Promotional Call ☐ Radio ☐ Insurance

☐ Yellow Pages ☐ Sponsored Event ☐ Health/Senior Fair ☐ Website ☐ Employer

☐ Referred by Friend: _____

☐ Referred by Physician: _____

☐ Other: _____

Insurance Information

Our expert insurance staff is happy to help verify your hearing benefits and coverage.

Do you have hearing aid coverage? Yes No I don't know

Do you want us to bill your insurance? Yes No

To bill your insurance and verify coverage, please provide the following:

☐ A copy of your driver's license or photo ID

☐ A copy of your insurance card(s)

☐ File to your insurance for covered products services

☐ DO NOT file to insurance for covered products & services

Name of Insurance Company

ID Number and Group Number

Insurance Cardholder Name (If different than patient)

Secondary Insurance (if applicable)

Insurance Cardholder Date of Birth

Secondary Insurance ID Number

*************PLEASE READ, INITIAL AND SIGN BELOW*************

____ I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my ☐insurance company, ☐rehab nurse, ☐case manager, ☐attorney, ☐employer, ☐physicians, ☐related healthcare providers, ☐assignees and/or beneficiaries and all other related persons.
Information without patient identifiers may be used for quality purposes.

____ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

____ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. If my insurance covers only basic products and services and I need and desire better technology and care, I understand that I am responsible for paying the difference, regardless of the amount that appears as "member responsibility" on any Explanation of Benefits (EOB) that I may receive from my insurance company. I agree to pay the difference between the Total Cost that appears on LHS/CHC Fitting Agreement and my insurance company's payment.

____ I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

Patient Signature: _____ Date: _____

A copy of this signature is as valid as the original