WISCONSIN HEARING AIDS, INC

# NEW PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SEX: ☐ M ☐ F

CITY: _____ STATE: _____ ZIP: _____

WORK PH #: _____ EMPLOYER: _____

CELL PH #: _____ EMAIL ADDRESS: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ PHONE: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____

RELATIONSHIP: _____ PHONE: _____

HAVE ANY OF YOUR FRIENDS OR FAMILY MEMBERS BEEN SEEN HERE? ☐ YES ☐ NO

THEIR NAME: _____

CHIEF COMPLAINT: _____

DO YOU CURRENTLY WEAR HEARING AIDS? ☐ YES ☐ NO

IF YES, APPROXIMATELY HOW OLD ARE THEY? _____ YRS

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

DO YOU WISH US TO SEND RESULTS TO THIS PHYSICIAN? _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____