Hear Well Again Centers
800-879-3432/610-359-0200/215-654-5395
fax 610-356-6180

PATIENT INFORMATION SHEET
(please print and fill out completely)

Today's Date:_____

Patient Name:_____

Addess: _____ Birthdate:_____

City:_____ State:_____ Zip:_____ Home Phone #:_____

Sex: Male_____ Female_____ Cell Phone #_____

Your Employer:_____ Marital Status: _____

Occupation:_____ Spouse's Name: _____

Referred by:_____ Spouse's Employer:_____

Patient Email Address:_____

Primary Physician Name: _____ Address: _____

Phone #:_____ City:_____ State:_____ Zip:_____

Insurance Information:
Primary Medical Insurance:_____

ID Number:_____ Group Number:_____

Subscriber's Name:_____ DOB:_____ Relationship:_____

Secondary Insurance Company:_____

ID Number:_____ Group Number:_____

Subscriber's Name:_____ DOB:_____ Relationship:_____

Emergency Contact Info:
Name:_____ Relationship:_____

Phone:_____

Would you like them contacted regarding today's evaluation? YES_____ No_____

Medical History (see other side)

3501 West Chester Pike, Suite 101
Newtown Square, PA 19073

1300 Virginia Drive, Suite 125
Ft. Washington, PA 19034

Patient Name: _____ Date: _____

Main Purpose of Visit:_____

_____

_____

_____

_____

_____

Noise Exposure: ◯ Occupational ◯ Recreational ◯ Military

Please explain:_____

Ear Infections: YES_____ No_____ Surgeries: YES_____ No_____

Pain/discomfort: YES_____ No_____ Tinnitus: YES_____ No_____

Dizziness: YES_____ No_____

Medical History: ◯ Hypertension ◯ Heart ◯ Diabetes ◯ Strokes ◯ Anxiety

◯ Depression ◯ AIDS ◯ Kidney ◯ T.B. ◯ Cancer

If yes, please explain: _____

_____

Family history of hearing loss: _____

_____

Other Medical Conditions:_____

_____

Medications you currently take: _____

_____

_____

Hearing Aid Use:

Make/Model: Right_____ Left _____

Age of aids: _____ Place of purchase: _____