MUTTER'S Hearing Center
HEAR BETTER - LIVE BETTER

1420 SW St. Lucie West Blvd. Ste. 101
Port St. Lucie Florida 34986
Phone: (772) 871-1222. Fax: (772) 873-4999

Patient Analysis Chart

Patient:_____ Home Phone: _____

Cell Phone: _____ Date of Birth: _____

Address: _____ City: _____ ST: _____

ZIP:_____ Email: _____

Marital Status: Married Single Widowed Name of Spouse: _____

How did you hear about us? (circle one) St. Lucie Voice TCPalm Facebook Google

Who may we thank for referring you or other:_____

Please complete the following questions:

1. **Have you ever had any type of ear surgery? Yes** _____ **No**
2. **Do you take any blood thinner medication, including Aspirin? Yes** _____ **No**
3. Do you have Hepatitis B or C, HIV OR AND STD's? Yes No
4. Have you ever seen a doctor specializing in diseases of the ear (ENT)? Yes No
5. Have you ever had your hearing tested? If so, how long ago? Yes No _____
6. Have you had sudden hearing loss within the last 90 days? Yes No
7. Have you had drainage from the ear or pain in the past 90 days? Yes No
8. Do you have a family history of hearing loss? Yes No
9. Do your ears ring or buzz? Yes No
10. Are you a heart, diabetic or cancer patient? (Circle all that apply)

Do you feel you need help with:

Understanding family, children, grandchildren or friends? Yes No

Understanding on the phone? Yes No

Understanding in a crowd? Yes No

Understanding a casual conversation? Yes No

Do you now or have you ever worn hearing aids? Yes _____ No

I, _____ authorize release of any and all records or information that Mutter's Precision Hearing Inc. may have about me, and permit a copy of this authorization to be used in place of the original. I authorize Mutter's Precision Hearing Inc. to act as my agent and assist in obtaining payment from my insurance companies if applicable, and authorize payment from my insurance companies if applicable, and authorize payment directly to Mutter's Precision Hearing Inc. or to the party who accepts assignment. I understand that I am responsible for my billing including co-payments and deductibles. In the event of non-coverage, I agree to assume responsibility of payment if my insurance denied for any reason whatsoever. I authorize the release of any of all of my medical information to other physicians and/or hearing healthcare providers or suppliers for the continuation of my care and treatment.

X_____ Date:_____