Chester Heights
Hearing Aid Center, LLC

CLIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

DATE OF BIRTH _____

HOW WERE YOU REFERRED TO US ? _____

DO YOU WEAR A HEARING AID? YES NO

IF YES, HOW LONG HAVE YOU WORN YOUR HEARING AID? _____

MAKE AND MODEL OF YOUR HEARING AID: _____

HAVE YOU HAD YOUR HEARING TESTED IN THE PAST? YES NO

IF YES, WHERE AND WHEN? _____

DO YOU HAVE HEALTH INSURANCE? YES NO

IF YES, WHAT IS YOUR INSURANCE COMPANY NAME? _____

Please note at your request and with a signed HIPAA form, we will forward the test results to your family physician.

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