clarity
The speech, hearing, and learning center.
Discovering Potential
Empowering Communication
Transforming Lives

29 North Academy Street | Greenville, SC 29601
p 864.331.1400 f 864.331.1416
www.clarityupstate.org

GENERAL INFORMATION

Client Name: ______________________________ DOB: ________________ ☐ Male ☐ Female

Address: ____
Street address City State Zip

Home Phone: _______________________________ Work Phone: _____________________

Email Address: ____
Your information will be kept strictly confidential and not divulged to any third parties.

Occupation: _________________________________ Employer: _________________________

Name of person referring you to Clarity: ____

Name and address of primary care physician: ____

____

Do you think you have a hearing problem? _______________ Do others? _____________________

When was this first noticed? ____

Did it happen gradually or suddenly? ____

What other symptoms occurred around the same time? ____________________________________

____

Possible cause of hearing loss? ____

Is there a family history of hearing loss? ____

MEDICAL HISTORY:

Have you been seen by a physician for your hearing loss? ☐ No ☐ Yes When:

By whom: ____

What was the diagnosis: ____

What treatment was given or recommended:____

Had you had or do you have any of the following: Please check all that apply to you and explain

☐ Serious illness: ____

☐ Blow to the head: ____

☐ Dizzy spells or loss of balance: (When, how often, and describe the dizziness, if you can)

____

____

☐ Ear infection: ☐ Right ☐ Left ☐ Both ______________________________

☐ Ear surgery: When? ________________ By Whom? ________________

☐ Ear pain: ☐ Right ☐ Left ☐ Both When and how often? ____________

____

☐ Ear drainage or running ears? When and how often? ________________

Do your ears ring or do you have other head noises? ☐ Yes ☐ No

☐ Right ☐ Left ☐ Both How often? ______________________________

____

Do your ears feel full? ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Do you have: (Please check those that apply)

☐ Diabetes
☐ Circulation problems
☐ Kidney Disease
☐ Heart Condition
☐ High Blood Pressures
☐ Other illnesses (please describe) ________________

____

____

Do you: (Please check those that apply)
☐ Feel like people mumble?
☐ Need the TV louder than others?
☐ Have trouble understanding conversation?
- ☐ In quiet from a distance?
- ☐ In quiet even when near to the speaker?
- ☐ In background noise?

____

____

NOISE HISTORY

Have you ever worked in a noisy job (include military service)? ☐ Yes ☐ No

If "Yes" what type of job did you do? ____

For how long? ____

Did you use hearing protection (earplugs/earmuffs)? ________________________________

For how long? ____

Do you or have you ever used guns? ☐ Yes ☐ No

If "Yes," how often? ____

Additional Information: ____

____

____

____

____

QUICK PATIENT PROFILE

1. What brought you to Clarity today? ____

   ____

2. How well do you currently hear in this environment?

	Well	Fair	Poor
One-to-one Conversations			
Quiet Room (1 to 2 people)			
Small Groups (4 to 6 people)			
Large Social Gatherings			
At the Work Place			
Watching Television			
During Religious Services			
Meetings/Lectures			
In the Car			
Outdoors			
On the telephone			

3. What is your experience with hearing aids? (Please check all that apply)

   ☐ I have never used or visited a Hearing Health Care Professional to ask about a hearing aid(s).

   ☐ I have been to another Hearing Health Care Professional to gather information regarding my hearing difficulties, but have not tried or purchased a hearing aid.

   ☐ I have tried a hearing aid(s) but returned the instrument(s).

   ☐ I have a hearing aid(s) but only wear it occasionally or not at all.

   ☐ I have a hearing aid and wear it regularly in the ___ right ear and/or ____ left ear.

4. Please rank the following in terms of importance in a hearing aid. (1-4 with 4 being the most important).

   ☐ Overall Sound Quality ☐ Reliability ☐ Style/Appearance ☐ Cost

5. On a scale of 1-10, how motivated are you regarding doing something about your hearing loss? (Please check one)

   ☐ 1-2 Not Motivated ☐ 3-4 Somewhat Motivated ☐ 5-6 Motivated
   ☐ 7-8 Very Motivated ☐ 9-10 Extremely Motivated

GENERAL FINANCIAL POLICIES

INSURANCE DISCLOSURE:

Please read and sign the following. If you have any questions about this form, please call Clarity's business office at (864) 331-1400.

I understand that am responsible for all costs not covered by my insurance company. These costs include, but are not limited to: service provided which are not covered by my policy, balances after insurance payment, or failure to obtain authorization before my appointment. I understand that I may be required to pay all amounts owed at the time services are rendered.

If there are any changes to you or your child's insurance between now and the time of your appointment, please notify us because your new insurance may not cover your services.

__________________________________ ______________________
Signature of Patient or Parent/Guardian **Date**

__________________________________ ______________________
Patient Name **Patients Date of Birth**

I authorize the release of any medical or other information to the insurance company that is necessary to process my insurance claim(s).

__________________________________ ______________________
Signature of Patient or Parent/Guardian **Date**

LATE CANCELLATION AND NO-SHOW POLICY

If for any reason, you are unable to keep this appointment, we request you call us 24 hours in advance at (864) 331-1400 to cancel or reschedule. If two appointments (in any six month time period) are missed or cancelled with less than 24 hour notice, we will reschedule the appointment after a six month waiting period from the time of the missed appointment.