129 E. Grant Street
West Point, NE 68788

1627 East Military Ave
Fremont, NE 68025

MENDLIK AUDIOLOGY

Patient Acct #: _____

Patient Information:

Name of Patient: _____

Date of Birth: _____ Social Security #: _____ Cell Phone: _____

Home Address: _____ City: _____St: _____ Zip: _____

eMail address: _____ Other Phone: _____

Emergency Contact Name/Relation: _____Their Phone: _____

Primary Care Physician: _____Referring Doctor: _____

Insurance/Payment Info:

Please fill out for Insurance/Payment purposes:

Responsible Party for Payment (please circle): Self Spouse Parent Other

Name of Paying Adult: _____ Date of Birth: _____

Home Address: _____ City: _____St: _____ Zip: _____

eMail address: _____ Other Phone: _____

Responsible Party's Place Employment: _____

Insurance Information: Please make a check next to the insurance coverage that applies:

1. ☐ Blue Cross/Blue Shield (including Medicare Supplement)
2. ☐ Champus (Military)
3. ☐ Group Insurance (through employment)*
4. ☐ Medically Handicapped Children's Program*
5. ☐ Medicaid (Department of Social Services)*
6. ☐ Medicare*
7. ☐ No Insurance/Self Pay
8. ☐ Private Insurance through an Agent (including Medicare Supplemental)*
9. ☐ Veterans Administration
10. ☐ Worker's Compensation or Personal Injury*

If there is an asterix (*) by your choice, please provide the following:

Name of Employer (if applicable): _____

Name of Insurance Company (if applicable): _____

Group Number: _____ Policy Number: _____

Name of Insurance Contact (if applicable): _____

Name of Agent (if applicable): _____

Services are rendered on a cash basis only unless previous credit arrangements have been made. The about information is warranted to be true. I agree to pay all bills upon receipt of the statement or as otherwise expressly agreed.

I authorize Mendlik Audiology to release to the Medicare carriers or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim to be made directly to Mendlik Audiology.

I understand that I am financially responsible for all charges insured.

Signature of paying adult: _____ Date: _____

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Patient Acct #: _____

Name of Patient: _____ Date of Birth: _____
Home Address: _____
City: _____ St: _____ Zip: _____

ADULT CASE HISTORY:

Do you have any pain in either ear today?	Yes / No
Have you had a sudden or rapid loss of hearing in the past 90 days?	Yes / No
Do you have acute or chronic dizziness that causes you to lay down to recover?	Yes / No
Do you have a loss that began in only one ear in the past 90 days?	Yes / No
Have you had ear surgery?	Yes / No
Do you have any head noises or tinnitus?	Yes / No

Is there hearing loss in your family? Please specify: _____
_____

Do you have allergies to Plastics?	Yes / No
Have you ever worn hearing aids in the past?	Yes / No

What type? _____ Dispensed by: _____

Do you take medication regularly? Specify: _____

Which is your better ear?	Right/Left/Same
Do you get confused about which direction a sound is coming from?	Yes / No
Have you working in noisy environmentsassembly lines, jackhammers, jet engines, etc.)?	Yes / No
Have you noticed that people seem to mumble?	Yes / No
Do you have to strain to understand conversations?	Yes / No
Do you have trouble hearing conversations in a noisy background such as a party or restaurant?	Yes / No
Do you misunderstand some words in a sentence and need to ask people to repeat themselves?	Yes / No
Do you especially have trouble understanding the speech of women and children?	Yes / No
Do people get annoyed because you misunderstand what they say?	Yes / No
Do you misunderstand what others are saying and make inappropriate responses?	Yes / No
Do you avoid social activities because you cannot hear well?	Yes / No
Do you have a problem hearing over the telephone?	Yes / No
Do people complain that you turn the TV volume too high?	Yes / No
Do you miss hearing some common sounds like the phone or doorbell ringing?	Yes / No
Has your ear drained any fluid in the past 90 days?	Yes / No

To be answered by a family member:

Do you think this person has hearing loss?	Yes / No
Is there visible or traumatic deformity of the ear?	Yes / No
Is there visible evidence of ear wax accumulation or foreign body in either ear canal?	Yes / No
Is there an Air/Bone gap in the pure ton test equal to or greater than 15dB at 500/1000/2000 Hz?	Yes / No

Otoscopic Check:

Right: Clean _____ Blocked _____ Other _____
Left: Clean _____ Blocked _____ Other _____

Patient Referred to: _____

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MENDLIK AUDIOLOGY

Patient Acct #: _____

Name of Patient: _____ Date of Birth: _____
Home Address: _____
City: _____ St: _____ Zip: _____

CHILD CASE HISTORY:

Age at which child's ability to hear was first questioned?	_____
Does your child have any pain or discomfort in either ear today?	Yes / No
Has your child had a sudden or rapid loss of hearing in the past 90 days?	Yes / No
Does your child have acute or chronic dizziness that causes him to lay down to recover?	Yes / No
Does your child have a loss that began in only one ear in the past 90 days?	Yes / No
Has your child had ear surgery?	Yes / No
Does your child have any head noises or tinnitus?	Yes / No
Is there hearing loss in your family? Please specify: _____	
Does your child fail to respond to ordinary sounds?	Yes / No
Was your child's birth normal?	Yes / No
Has your child been hospitalized for any illness?	Yes / No
Please specify: _____	
Does your child misunderstand conversations?	Yes / No
Does your child frequently ask you or classmates to repeat?	Yes / No
Does your child speak in a voice that is too loud or too soft?	Yes / No
Does your child show extra attention to your face when you are speaking?	Yes / No
Does your child daydream and have difficulty paying attention for a length of time?	Yes / No
Does your child have a speech that is difficult to understand?	Yes / No
Does your child depend on visual clues or gestures, such as pointing?	Yes / No
Does your child say "huh" or "what" frequently?	Yes / No
Does your child tilt his or her head to one side when listening?	Yes / No
Does your child gave difficulties following directions?	Yes / No
Has your child's ear drained any fluid in the past 90 days?	Yes / No

Is there visible or traumatic deformity of the ear?	Yes / No
Is there visible evidence of ear wax accumulation or foreign body in either ear canal?	Yes / No
Is there an Air/Bone gap in the pure ton test equal to or greater than 15dB at 500/1000/2000 Hz?	Yes / No

Otoscopic Check:

Right: Clean _____ Blocked _____ Other _____
Left: Clean _____ Blocked _____ Other _____

Patient Referred to: _____