

Hermiston Hearing Aid Center LLC

## PATIENT HEARING ASSESSMENT

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Insurance Provider \_\_\_\_\_

Social Security # \_\_\_\_\_

How Did You Hear About Us?  Newspaper  Mail  Yellow Pages  Internet

Phone Call    Physician/Friend Referral: \_\_\_\_\_ Other: \_\_\_\_\_