ADDITIONAL INFORMATION

Have you ever worn a hearing aid? □ Yes □ No Make: ________________ Model: ____________________

Explain any difficulties you have in using your hearing aid: ____

____

What was you reason for coming to Hearing Health Center? ____________________________________

____

How did you hear about our services?

□ Doctor Referral
□ School
□ Friend
□ Yellow Pages
□ Previous Patient
□ Advertisement
□ Other ____________________
____
____

Authorization for Release of Information

I authorize the Hearing Health Center of 1200 E. Michigan Ave. Suite 330, Lansing, MI 48912 to release any part or all of my records to the following agencies and professional persons:

Name: **Address:**

Signature: ____

Relationship to patient: ______________________________________

Date: ______________________