EARS
Ear Associates & Rehabilitation Services Inc.

Patient Name: _____

Date of Birth: _____

Insurance: _____

MEDICAL CONSULTATIONS:	**TESTING AND THERAPY:** *(Please check these boxes if you would like the patient to come in for one of these services without seeing a physician at EARS Inc.)*
☐ Hearing Loss ☐ Sudden Hearing Loss ☐ Hearing Aid Evaluation ☐ Tinnitus ☐ Vertigo/Imbalance ☐ Acoustic Neuroma ☐ Otosclerosis ☐ Chronic Otitis Media ☐ Eustachian Tube Dysfunction ☐ Cholesteatoma ☐ Ear Pain ☐ Plugged Ear ☐ CI Evaluation ☐ BAHA Evaluation ☐ Middle Ear Implant Evaluation	☐ Audiogram ☐ Immittance Only ☐ Hearing Aid Consultation ☐ ABR ☐ ENG ☐ ECOG ☐ CDP ☐ Tinnitus Evaluation with Audiologist

☐ Cochlear Implant Evaluation
☐ BAHA Evaluation
☐ Middle Ear Implant Evaluation

How would you like us to send the reports to you? ☐ Mail ☐ Fax