Hearing HealthCare, Inc.

Complete Audiology Services Name:_____

MEDICATION NAME: includes prescription, over the counter, vitamins and herbal supplements	Dose? (mg, ml, IU)	Times Per Day?	How is it administered? (oral, patch, inhalant, injection, etc)	Why do you take it?

ARE YOU A CURRENT TOBACCO USER? ___ YES ___NO

In order to stay compliant with new insurance regulations, we are required to review your most current prescriptions, over-the-counter medications and vitamins/herbal supplements.

We are also required to ask about your tobacco use. If you are a current tobacco user, we will provide you with information regarding smoking cessation.

PLEASE SIGN BELOW THAT THE ABOVE LIST IS CORRECT AND COMPLETE TO THE BEST OF YOUR ABILITY.

Patient Signature:_____ Date of Initial Review:_____

Audiologist Signature:_____

FOR OFFICE USE ONLY: DATE OF SUBSEQUENT MEDICATION REVIEWS:

_____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____