HEARING AID URGENT CARE   EAST COAST AUDIOLOGY AND PHYSICAL THERAPY   FYZICAL® Therapy & Balance Centers

Date: _____ / _____ / ______

Patient Name: ______________________________________ Date of Birth: _____ / _____ / ______

New Patient ☐ Existing Patient ☐

Mailing Address (Street, City, State, Zip): ____

____

Home Phone: ______________________ Work Phone: ______________________

Cell Phone : ______________________

DESCRIPTION OF DEFECTS

(Please Check Applicable Boxes)

Left Hearing Aid ☐ **Right Hearing Aid** ☐

Dead ☐ **Fades** ☐ **Intermittent** ☐ **Moisture Damage** ☐ **Tele Coil Dead/Weak** ☐

Noisy ☐ **Weak** ☐ **Distorted** ☐ **Excessive Battery Drain** ☐

Other Issues with Hearing Aid(s): ____

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DATE:	**TEMPERATURE:**	
1) Have you had a positive test for the Covid-19 virus in the past 14 days?	**Yes** ☐	**No** ☐
2) Are you showing any one or more signs of the following symptoms? Temperature > 100.4 or higher, cough, shortness of breath, difficulty breathing, tiredness	**Yes** ☐	**No** ☐
3) Are you showing at least two of the following symptoms? Fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell	**Yes** ☐	**No** ☐
☐ **By checking this box you acknowledge the information provided on this form is true and correct to the best of your knowledge.**		