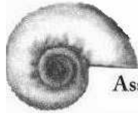

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HEARING AID DROP OFF/PICK UP FORM

Patient name: ____ Date:________________ Phone:____________

Hearing Aid Information:

Manufacturer- Right:__________________________ Left:__________________________

Serial Number- Right:__________________________ Left:__________________________

Problem: *(check all that apply)*

Dead___ Weak_____ Feedback/Squealing_____ Intermittent/Fades_______Broken Battery Door______

Battery lodged in aid_______Short Battery Life___Broken/cracked case_______Tubing problem_____

Needs wax guard(s)________ Other: (*describe*) ____

*Received by office staff*_____________________________________Date:__________________________
Initials

Received by patient:

Signature: ____Date:__________________________

No payment due: ____Date:__________________________
Initials

Balance due of: $ ______________________Initials:____________Date:__________________________

Comments: