PAST HEARING TESTS

Claimant Name _____ **Social Security Number** _____

Address _____ **Telephone** _____

City/State/Zip: _____

PAST HEARING TESTS

Please list all medical providers who have treated you and medical facilities where you have been treated in the last ten years. This includes your primary care physician and any provider who has treated you for hearing loss or tested your hearing.

_____ _____

(Name) **(Name)**

_____ _____

(Address) **(Address)**

_____ _____

(City, State) **Zip** **(City, State)** **Zip**

_____ _____

Telephone **Telephone**

_____ _____

(Name) **(Name)**

_____ _____

(Address) **(Address)**

_____ _____

(City, State) **Zip** **(City, State)** **Zip**

_____ _____

Telephone **Telephone**

Please attach additional pages, if necessary.