Welcome to our hearing clinic!

In order for us to serve you best, please provide the following information.

Mr. Mrs. Ms. Miss Dr. _____

DOB (dd/mm/yyyy): __ __ /__ __ /__ __ __ __ Health card number: __ __ __ __ __ __ __ __ __ __ (__ __)

Your home address: _____

City: _____ Postal code: _____

e-mail address: _____ To receive correspondence: ☐ Yes ☐ No

Phone # (HOME): (__ __ __) __ __ __- __ __ __ __ (CELL): (__ __ __) __ __ __- __ __ __ __

Family physician: _____ (Physician Phone #): (__ __ __) __ __ __ - __ __ __ __

*I consent to the release of my results to my physician(s)? ☐ Yes ☐ No

Do you have private insurance: _____ Ins. #: _____ OR

☐ DVA/VAC ☐ WSIB ☐ ODSP ☐ GREEN SHIELD Ins. #: _____

*I consent to Advanced Hearing contacting my insurance provider on my behalf. ☐ Yes ☐ No

How did you HEAR about us? ⇩

Advertising	**Internet**	**ENT**	**Physician**
□ Flyer / Postal walk	□ E-mail	□ Dr. _____	□ Dr. _____
□ Direct Mail	□ Facebook		
□ Newspaper	□ Google		
□ Radio	□ Online Yellow Pages		
□ Television	□ Our website		
□ Yellow Pages book			
Signage	**Networking**	**Other**	
□ Signage	□ Wellness fairs	□ DVA	□ Legion
□ Driving by	□ Presentation	□ WSIB	□ Teacher
□ Walk-in	□ Event	□ ODSP	□ Speech Language Pathologist
	□ Seniors Centre	□ IHP	□ Family or Friend:
		□ CHS	_____

Medical History ⇩

Are you diabetic? □Y □N Are you on blood thinners? □Y □N

Do you have a pacemaker? □Y □N Is there any memory loss or dementia in your family? □Y □N

We observe the Privacy Act and will keep your information **strictly confidential**. If you would like us to discuss your hearing particulars with a family member or friend, please provide their name: _____ and relationship: _____.

Thank you for completing these forms.

Date: _____ Signature: X_____