Hear Clear CANADA

Patient Intake Form

(Please fill out both sides)

Personal Information

Name: _____ (First/Last) Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ Cell Phone: _____

Postal Code: _____ Health Card#: _____

e-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Consent for Disclosure

Due to the privacy legislation, we will not disclose your personal information to any third parties without your consent. If you agree to share your personal information with your physician or insurance company, please check the appropriate boxes (below) and sign this form.

Hear Clear Canada may share my information with my physician ◯ Yes ◯ No

Do you have an Extended Health Insurance Plan? ◯ Yes ◯ No

Insurance Company: _____

Certificate#: _____ Group/Plan/Policy#: _____

Hear Clear Canada may share my information with my insurance if needed ◯ Yes ◯ No

Client Signature: _____ Date: _____

Hearing & General Health History

Have you had an Ear, Nose & Throat (ENT) consultation?

◯ Yes ◯ No Name: _____

Were you referred by your family doctor?

◯ Yes ◯ No Name: _____

Have you ever had your hearing tested?	◯ Yes	◯ No
Have you had any ear infections in the last month?	◯ Yes	◯ No
Have you had any type of ear surgery? If Yes, please describe below	◯ Yes	◯ No

_____

Do you have any "ringing", painfullness / pressure in your ear(s)?	◯ Yes	◯ No
Do you suffer from dizziness or vertigo?	◯ Yes	◯ No
Which is your worse ear?	◯ Left	◯ Right
Is there a history of hearing loss in your family?	◯ Yes	◯ No
Have you purchased hearing aids in the past? If Yes, what is the name and approx. date	◯ Yes	◯ No

_____

Noise Exposure? If Yes, explain ear protection used?	◯ Yes	◯ No

_____

Have you suffered from any of the following? (Circle all that apply)

◯ Strokes	◯ Heart Problems	◯ Pacemaker	◯ Headaches
◯ Diabetes	◯ Allergies	◯ Tympanostomy Tube	◯ Shingles
◯ Head Trauma	◯ High Blood Pressure	◯ Ear Drum Performation	◯ Medications

Personal Hearing Information

Are you working or volunteering?	✔ Yes	◯ No
Do you have a problem hearing in a group or noisy environment?	◯ Yes	✔ No
Do some people seem to mumble?	◯ Yes	◯ No
Do you regularly have to ask others to repeat themselves?	◯ Yes	◯ No
Do you have difficulty understanding on the television?	◯ Yes	◯ No
Do family members or friends say you do not hear them?	◯ Yes	◯ No
Do you feel your hearing is not as good as it used to be?	◯ Yes	◯ No