INTAKE FORM

Personal Information: Date: _____

First Name:_____ Middle Initial:____ Last Name:_____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Birth Date (day/month/year):_____Age: _____ Gender: M / F

Health Card Number: _____Version _____

Phone Number: _____Cell Number: _____

Email Address: _____

Family Doctors Name: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? Mail / Office Sign / Newspaper / Website / Yellow Pages

Referred by Friend: _____

Referred by Physician: _____

Have you had a previous hearing evaluation? If so, Where?_____

Do you now, or have you ever worn hearing aids? YES / NO Purchased date _____

Do you qualify for any of the following? (Please circle)

Veteran's Affairs (DVA) Worker's Compensation (WSIB) Private Insurance

Aboriginal Affairs Ontario Disability(ODSP) Ontario Works

I.D./ Claim Number: _____

Release of Information

I authorize and request Frontenac Hearing Clinic to obtain, release, and or exchange medical and health information with my family physician. I understand that my information will be kept strictly confidential. Frontenac Hearing Clinic may need to exchange information with third party payers (ADP, private insurance, WSIB, VAC etc.).

Patient Signature: _____