

Patient Last Name: _____ **First Name:** _____
(as it appears on health card)

Preferred Name: _____ **Health Card #:** _____
(if different)

Address: _____

City: _____ **Postal Code:** _____ **Phone:** _____

Email: _____

Date of Birth (DD/MM/YYYY): _____ **GENDER:** _____

WSIB DVA HCAI ODSP NIHB OW/DB GREENSHIELD ID #: _____

Occupation: _____ **Retired:** YES NO

Family Doctor: _____ **Address:** _____

Emergency Contact/POA Name: _____ **Phone #** _____

Relationship: _____

POA Address: _____ **City:** _____ **Postal Code:** _____

Hearing testing and amplification prescriptions are performed by Audiologists who are regulated by the Regulated Health Professions Act (RHPA). Some services such as hearing aid maintenance and instructions for care are provided by trained Hearing Instrument Dispensers and Audiology Assistants who are not regulated under RHPA. London Audiology Consultants will collect personal information to serve its client's needs and will maintain the security and privacy of this information in accordance with our privacy policy, which is available to read. If hearing aids are ordered, personal information released to the manufacturer will include name, date of birth, hearing test results and information about the size and shape of the ears. If you are covered by a third party insurance that receives special pricing from the hearing aid manufacturers we are required to provide your identification number for billing purposes. I consent to the collection of this information.

Signature: _____ **Date:** _____

1. How did you hear about us? _____
2. Have you had your hearing tested before? _____ When and where? _____
3. Do you have ringing or buzzing in your ears or head? _____
4. Have you had any exposure to loud noise? _____
5. Does anyone in your family have a hearing loss? _____ Who? _____
6. Have you worn hearing aids previously? YES NO If "Yes" year purchased _____