IMPORTANT: Save document to computer,
Open from saved location to complete electronically

## CLIENT REGISTRATION

Title (Mr/Ms/Mrs): ______ First Name:____________________ Initial:___ Surname:____________________

DOB (DD/MM/YYYY): _____/______/_________ Health Card#: ______________________ VC (ON): ______

Apt/Unit: _________ Street#: _________ Street:________________________________________

City: ______________________ Province: __________ Postal Code:_______________

Tel (Home): (___)______________ Tel (Work): (___)___________Ex.____ Tel (Cell): (___)_____________

Here is my email address, please send me appointment reminders, hearing tips, newsletters, and offers:
**Email:** ____________________________________________________________

Family Physician: ______________________________ Physician Tel: (____)______________________

Physician Address: ________________________________City:____________ Postal Code:___________

**I am eligible to receive healthcare benefits from the following third party program(s):**

☐ Worker's Compensation ☐ Veteran Affairs ☐ Disability Support ☐ First Canadian Health (NIHB)
☐ Private Insurance ☐ Other __________________ | Program ID#: _____________________

**What or who prompted you to visit us today? (Check one)**

☐ Friend/Relative ☐ Doctor ☐ Audiologist ☐ Radio Ad ☐ Yellow Pages
☐ Email Ad ☐ Newspaper ☐ Flyer ☐ Letter ☐ Internet search
☐ Phone call Promo code on bottom right corner of advertisement:___________________________

## ALTERNATE CONTACT INFORMATION (IF APPLICABLE)

Title: _____ First Name:_____________________ Initial:____ Surname:________________________

Relationship to Client: __________________________________ ☐ Primary Contact (Check if applicable)

Tel (Home): (___)______________ Tel (Work): (___)___________Ex.____ Tel (Cell): (___)_____________

Here is my email address, please send me appointment reminders, hearing tips, newsletters, and offers:
**Email:** ____________________________________________________________

## CONSENT FOR PERSONAL INFORMATION

*Pursuant to the Personal Information Protection and Electronic Documents Act and the applicable provincial privacy and personal health legislation in effect from time to time:*

I authorize **HearingLife & Affiliated Providers** ("the Company") to collect and use my personal information, including personal health information (e.g. the results of my hearing test, my health card number, my contact information and my recommended or prescribed treatment, etc.) in accordance with the Company's Privacy Policy.

**Please note:** Under no circumstance will we sell patient lists or other personal information to third parties.

*Enter your first and last name below to verify that you've acknowledged and consented to the above terms.

**Electronic Signature:** [ ] **Date:**_________________________

**Please forward copies of my reports** to the following medical professional(s) or organization/employer*:

☐ *Check Here to Send to Family Physician Listed Above* *Copies of audiograms for personal use will incur a fee

Name:_____________________________________ Name:_____________________________________

Address:___________________________________ Address:___________________________________

___________________________________________ ___________________________________________

NAME: ___________________________ DATE: __________ **CONFIDENTIAL CLIENT HISTORY - MEDICAL**

| | | |
|---|---|---|
| 1. Have you ever been referred to a Specialist or Ear, Nose and Throat Doctor for your hearing? If YES, please explain when and why: | Y | N |
| 2. Do you ever hear buzzing or ringing in your head? If YES, please indicate which ear(s) : Left: ☐ Right : ☐ And how often : Constantly ☐ Rarely ☐ Quiet Situations ☐ | Y | N |
| 3. Do you ever experience fullness or stuffiness in your ears? | Y | N |
| 4. Do you ever experience numbness, weakness or tingling in your face? If YES, please explain when: | Y | N |
| 5. Do you ever experience dizziness? If YES, please indicate other symptoms during dizziness: | Y | N |
| 6. Have you ever had surgery on your head, neck and/or ears? If YES, please explain where, why and if follow-up is necessary: | Y | N |
| 7. Do you have any history of excessive noise exposure? If YES, please indicate where and if noise protection was used: | Y | N |
| 8. Do you take medications regularly? If YES, please list: | Y | N |
| 9. Does anyone in your immediate family have a hearing problem? If YES, please indicate whom: | Y | N |
| 10. Have you had chemotherapy or radiation on your head or neck region? | Y | N |
| 11. Please indicate any medical conditions that are applicable to you:<br>☐ Ear Infections ☐ Mumps ☐ Hepatitis ☐ Meningitis<br>☐ Multiple Sclerosis ☐ Heart Problems ☐ Head Injuries ☐ Ear Pain<br>☐ HIV ☐ Allergies ☐ Headaches ☐ Diabetes<br>☐ Pacemaker | CHECK ALL THAT APPLY | |
| 12. Have you ever had your hearing tested? If YES, please indicate when:<br>Result: ___________________________________<br>Have you ever noticed a change in your hearing since your last test? Yes ☐ No ☐ | Y | N |
| 13. Do you have difficulty hearing or understanding conversations?<br>If YES, please indicate which ear(s) : Left ☐ Right ☐<br>Did the changes happen : Suddenly ☐ Gradually ☐<br>Do your hearing difficulties fluctuate? Yes ☐ No ☐ | CHECK ALL THAT APPLY | |

| | | |
|---|---|---|
| 14. Please check all that apply:<br><br>I currently wear a hearing aid : ☐ Left Ear ☐ Right Ear How old is the aid(s) ____<br>I have worn a hearing aid in the past ☐ Left Ear ☐ Right Ear<br>I have never tried a hearing aid before ☐ | CHECK ALL THAT APPLY | |
| 15. Do you have trouble having a conversation on the telephone? | Y | N |
| 16. Which ear do you prefer to use on the telephone? Left ☐ Right ☐ | CHECK ALL THAT APPLY | |
| 17. Do you have trouble understanding conversations due to background noise? | Y | N |
| 18. Do others often tell you the television or radio is too loud? | Y | N |
| 19. Do you have trouble following group conversations? If YES, has it stopped you from attending social gatherings or group activities? Yes ☐ No ☐ | Y | N |
| 20. Do you have trouble participating in conversations in the car? | Y | N |
| 21. Which situations do you find challenging?<br><br>☐ Conversation with one person<br>☐ Talking on the phone<br>☐ Listening to the TV/radio<br>☐ Talking on a cellphone<br>☐ Conversation with a small group<br>☐ Conversation in the car<br>☐ Conversation in a quiet restaurant<br>☐ Meetings<br>☐ Movies or theatre<br>☐ Family gatherings<br>☐ Places of worship/auditorium<br>☐ Conversation in a busy restaurant<br>☐ Grocery store or shopping mall<br>☐ Outside in traffic<br>☐ Live music/theatre<br>☐ Outdoor activities (walking, golf, etc.)<br>☐ Other: ____________________ | CHECK ALL THAT APPLY | |
| 22. Are you a **member** of the following organizations and associations?<br><br>☐ Air Miles<br>☐ ARTA (Alberta Retired Teachers Association)<br>☐ BCGREA (BC Government Retired Employees Association)<br>☐ BCRTA (BC Retired Teachers Association)<br>☐ Blue Cross (Blue Advantage)<br>☐ Blue Cross VIP Student Program<br>☐ CARP (Canadian Association of Retired Persons)<br>☐ Canadian Force Appreciation<br>☐ Edvantage/OTIP<br>☐ Legion<br>☐ National Association of Federal Retirees<br>☐ Perkopolis<br>☐ QCC (Quarter Century Club)<br>☐ Red Hat Society<br>☐ Sun Life Financial Group<br>☐ UNIFOR<br>☐ UBCAA (University of BC Alumni Association) | CHECK ALL THAT APPLY | |