Maple Gate Medical Building
2200 Rutherford Road, Suite 202
Vaughan, Ontario L4K 5V2
905-303-4327

Date: _____

For Office Use Only
- ☐ **ADP added as insurer, if applicable**
- ☐ **Address and name confirmed**
- ☐ **Email added to system**

Patient Intake Form

Reason for Appointment: _____

How did you hear about us? _____

Patient Contact Information

First Name: _____ Last Name: _____

Mailing Address: _____

Email Address: _____

Family Doctor: _____

If patient is under age 18 please answer the following:

Parent/Guardian Name (PLEASE PRINT) _____

Did you child pass his/her newborn infant hearing screening? ☐ Yes ☐ No ☐ Unsure

Hearing and Medical History					
☐	Near/far sighted or glaucoma	☐	Itchy ears	☐	Cancer
☐	Ear Surgery	☐	Ear Pain	☐	Diabetes
☐	Ear Infections	☐	Dizziness	☐	Heart issue
☐	Chronic Earwax Buildup	☐	Sensitive to sounds	☐	Speech or Language Delay
☐	Developmental Delay	☐	Blood Pressure	☐	Other: _____

Medication List

Verbal consent for services obtained ☐

Consent for Services

☐ I consent to the release of my hearing test report to my doctor listed above.

☐ I agree to receive email correspondence for appointment reminders and other office news communications.

Signature: _____

Kindly turn the page to complete this form for individuals who are 18 years of age or older >

Your Hearing Profile

Which ear do you hear <u>better</u> from: ☐ Right ear ☐ Left ear ☒ Same in both ears

Do you experience noises in your ears or head (tinnitus)? If so, where: _____

Have you ever worked or played around loud noise? If so, please explain: _____

How ready are you to do something today to: (Circle number below)

	Not ready									I'm Ready
Hear better	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Manage tinnitus	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Please check the top <u>THREE</u> listening situations where you would like to hear better.

☐ Television ☐ Telephone ☐ Spouse ☐ Meetings ☐ In background noise ☐ Driving

☐ Music ☐ Outdoors ☐ Religious ☐ Other _____

Does your hearing problem…

	<u>Frequently</u>	<u>Sometimes</u>	<u>Rarely</u>
Make it difficult for you to converse on the phone? …	☐	☐	☒
Cause you to turn up the TV or radio to hear it? …	☐	☐	☒
Cause you to have difficulty following conversations at a restaurant?…	☐	☐	☒
Limit your social or personal life? …	☐	☐	☒
Cause you to have to ask people to repeat themselves? …	☐	☐	☒
Cause you to have difficulty hearing when in the presence of background noise? …	☐	☐	☒
Cause you to have difficulty hearing women's or children's voices? …	☐	☐	☒
Cause you to hear people speak but fail to understand what they are saying? …	☐	☐	☒
Cause you to feel as though others mumble? …	☐	☐	☒
Cause you to feel stressed or tired when listening for long periods of time? …	☐	☐	☒

Current or Previous Hearing Aids

	Manufacturer, Model & Style	Serial Number	Date of Purchase
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Do you use a cellular phone? ☐ **Yes** ☐ **No** **If so, which cell phone do you use?**

☐ iPhone _____ ☐ Android _____ ☐ Other _____