BLUEWATER HEARING

Name:_____ Date of Birth:_____

Address:_____
Street City/Town Postal Code

Phone:_____
Home Cell Work

Alternate contact name & number:_____

Family Doctor:_____

How did you hear about us?_____

Email address:_____

Do you have a hearing loss?	Yes ___	No ___
Do you feel the onset of your hearing loss was	Sudden ___	Gradual ___
Do you hear better in one ear?	Yes ___	No ___
Which ear do you talk on the telephone?	Right ___	Left ___
Do you have ringing in your ears?	Yes ___	No ___
Do you experience dizziness/balance problems?	Yes ___	No ___
Have you ever had a hearing test?	Yes ___	No ___
Do you have family with a hearing loss?	Yes ___	No ___
Have you ever had ear surgery?	Yes ___	No ___
Do you suffer from ear infections?	Yes ___	No ___
Have you had head trauma?	Yes ___	No ___
Have you been exposed to loud noise through work/hobbies?	Yes ___	No ___
Have you worn hearing aids?	Yes ___	No ___

Please check all medical conditions:

Kidney ___ Liver ___ Diabetes ___ Arthritis ___
Heart Condition ___ Sinus ___ Allergies ___ High Blood Pressure ___ Vision ___

Are you currently taking blood thinners? Yes ___ No ___

Are there any other medical conditions that we should be aware of? Yes ___ No ___

Notes:

Please Sign Consent to Assessment and Release of Information on the Back of this Form. ▶

Sarnia: 714 London Road
Sarnia Ontario N7T 4X6

Petrolia: 4130 Glenview Road
Petrolia, Ontario N0N 1R0

Corunna: 348 Lyndoch Street
Corunna, Ontario N0N 1G0

BLUEWATER HEARING

CONSENT TO ASSESSMENT AND RELEASE OF INFORMATION

Client Name:_____Date of Birth:_____

I, _____
(CLIENT/PARENT/LEGAL GUARDIAN-PLEASE PRINT)

☐ Consent to an assessment by Blue Water Family Hearing of the above client.

☐ Consent to sharing information about this client with those listed below. (For example; family physician, specialists, school, community or other agencies) Please give the name of the school if your wish the school/teacher to receive information. Please include addresses of out-of-town physicians, if possible.

☐ I understand that the report of the initial assessment will be sent to the referring physician and that I will be placed on a recall list if needed.

Information may be transmitted by fax or electronically.

1._____
2._____
3._____
4._____
5._____
6._____

☐ I would like to receive information by e-mail (please initial) _____
(I understand that e-mail is NOT confidential)

The client/parent/legal guardian may change or revoke details of this consent at any time.

_____	_____	_____
Signature of person completing this form	**Relationship to child**	**Date**

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