PROFESSIONAL HEARING SERVICES

of

AJAX, BOWMANVILLE, NEWCASTLE, SCARBOROUGH & WHITBY

Name: _____ ☐ Female ☐ Male

Address: _____ Suite or Unit: _____

City: _____ Postal Code: _____

Telephone: _____ Business: _____ Cell: _____

Email: _____

Family Doctor: _____ City/Town Located: _____

Date of Birth: mm | dd | yyyy Health Card # _____ Version

Reason for visit or primary concern: Expiry date: mm | dd | yyyy

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Have you ever had your hearing tested before? ☐ Yes ☐ No

If yes, when and where? _____

Do you currently wear hearing aids? ☐ Yes ☐ No How old are they?

Do you have third party insurance? Circle if applicable WSIB OWP/ODSP DVA NIHB PRIVATE

RATE YOUR HEARING Please Circle

In a quiet room talking with one or more family members or close friends:

1 2 3 4 5 6 7 8 9 10
Can't hear at all — Hear about half — Hear Everything

In a restaurant talking with two or three family members or close friends:

1 2 3 4 5 6 7 8 9 10
Can't hear at all — Hear about half — Hear Everything

At a party with music playing and talking with many family/friends/acquaintances:

1 2 3 4 5 6 7 8 9 10
Can't hear at all — Hear about half — Hear Everything

Are you or family/friends complaining about the volume on the television? (too soft/too loud):

1 2 3 4 5 6 7 8 9 10
Often and/or ongoing — Occasionally — Rarely if ever

"Improving the quality of life of all those we meet through better hearing"