3080 Yonge St., Suite 4074, Box 4
Toronto ON M4N 3N1
416-488-4422

Global Hearing Aid Clinic

1386 Bayview Ave., Unit 3
Toronto ON M4G 3A1
416-482-4333

PATIENT INTAKE FORM

Title: (please circle)		**Simply Hearing #:**	**Audiologist:**	**Location:**
Mr	Dr	First Name		Last Name
Ms	Fr			
Mrs	Judge			
Miss	Rabbi	Sex: M F (please circle)	Date of Birth (dd/mm/yy):	
Mstr	Sister			
Address		Street: City/Province/Postal Code:		
Telephone		Primary Contact No.:		Home Work Cell
		Secondary Contact No:		Home Work Cell
Email Addresses		1st:		Personal Work Other
		2nd:		Personal Work Other
Private/3rd Party Contributors:				
OHIP #		VC:		WSIB Claim #:
DVA #				Other:
Family Doctor				
First Name			Last Name	
Address		Street: City/Province/Postal Code:		
Telephone:			Fax:	
Emergency Contact Person				**Relationship to Patient:**
First Name			Last Name	
Address		Street: City/Province/Postal Code:		
Telephone:		Email Address:		
Preferred Person to be Contacted (*if applicable*)				**Relationship to Patient:**
First Name			Last Name	
Address		Street: City/Province/Postal Code:		
Telephone:		Email Address:		
How did you hear about us?				
Yellow Pages		Internet		Doctor: _____
Addressed/Unaddressed Mail		Facebook/Twitter		Family or Friend: _____
Signage		Newspaper		Other: _____
Authorization for Release of Information				

Under section 42 of the personal information protection and electronic documents act, I give permission for release of reports, test results, recommendations and personal information to and from my family physician, the referral source, 3rd party contributor or others as specified.

_____ _____

Signature (and relation to patient, for minors) **Date**