15250 Thrift Ave
White Rock, BC, V4B 2L2
www.peninsulahearing.ca
Tel: (604) 245-4025, Fax (604) 245-4051
Adam Medeiros
Registered Hearing Instrument Practitioner

Date: _____

MY CONSENT AND INTAKE FORM

(Mr/Ms/Mrs) First Name: _____ Initial:___ Surname: _____

Date of Birth: _____/_____/_____ Phone:_____ Mobile:_____

Street: _____ City: _____ Postal Code: _____

Personal Health Card # _____ Health Insurer: _____

Family physician: _____ ENT Specialist?:_ _____

Alternate contact name: _____ Phone(s):_____

Here is my email address, for appointment reminders, hearing tips, my audiogram, and my warranty information:

Email: _____

Please check the circle if you have experienced or been diagnosed with any of the following:

- ○ history of sudden or rapidly progressive or fluctuating hearing loss;
- ○ active drainage or bleeding from the ear(s), in the preceding 90 days
- ○ ongoing pain or discomfort in the ear;
- ○ unilateral or pulsatile tinnitus;
- ○ acute, recurring episodes or chronic dizziness, or increasing imbalance;
- ○ facial numbness, tingling or paralysis of one side of my face.
- ○ difficulty hearing conversations in social or group conversations

- ○ diabetes;
- ○ blood thinners;
- ○ ear infections;
- ○ pressure-equalizing tubes;
- ○ chemotherapy;
- ○ Hepatitis;
- ○ excessive noise exposure.

I consent to receiving audiometry, tympanometry, real-ear-measures, earmold impressions, cerumen management and otoscopy as prescribed by the clinic and in the interest of my hearing health. I also understand that I can request for these procedures to be stopped at any time. I have revealed the history of my ears and any ear-related injuries or diseases to the clinic staff so they can choose the appropriate course for my hearing care.

Pursuant to the Personal Information Protection & Electronic Documents Act and the Personal Information Protection Act:
I authorize Peninsula Hearing staff to collect, use and store my personal information, as is reasonably necessary for the purpose of me receiving hearing healthcare services, and in accordance with Peninsula Hearing's Privacy Policy (www.peninsulahearing.ca) and applicable laws. I agree that Peninsula Hearing may share my personal information and audiologic reports with my family physician, health benefits provider or the alternate contact I've listed above, or otherwise if required under applicable laws. I get that Peninsula Hearing is committed to protecting the confidentiality of my information by use of locked paper files and encrypted digital records which are hosted from time to time on password-protected audiologic software such as Hearing Instrument Manufacturers' Software Association (HIMSA), whose servers are secured, audited and housed internationally (Europe, Australia and USA).

Peninsula Hearing does not sell patient lists or other personal information to third parties.

Signature: _____ Date: _____