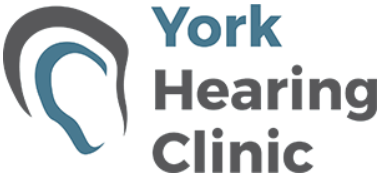
Intake Form



Personal Information As it appears on your health card

First Name: _____ Middle Initial: _____ Last Name: _____

Title: Mr / Mrs / Ms / Miss / Dr Marital Status:_____

Birth Date (d/m/y): _____ / _____ / _____ Age: _____ Gender: M / F

Health Card #: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Email: _____

Alternate Phone (Work/Cell): _____

Occupation: _____

Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

How did you hear about us?

- ☐ Mail
- ☐ Newspaper
- ☐ Website
- ☐ Yellow Pages
- ☐ Google Search
- ☐ Facebook
- ☐ Office Sign
- ☐ Referred by Friend: _____
- ☐ Referred by Physician: _____
- ☐ Other: _____

Do you qualify for any of the following?

- ☐ Veteran's Affairs (DVA)
- ☐ Worker's Compensation (WSIB)
- ☐ Blue Cross
- ☐ Green Shield
- ☐ Aboriginal Affairs
- ☐ Ontario Disability (ODSP)
- ☐ Special Needs
- ☐ Ontario Works

I.D/Claim #: _____

Release of Information

I authorize and request York Hearing Clinic to obtain, release, and/or exchange medical and health information with my family physician. I understand that my information will be kept strictly confidential. York Hearing Clinic may need to exchange information with third party payers (ADP, private insurance, WSIB etc.).

Client Signature: _____ Date: _____