CLIENT REGISTRATION FORM

Hearing Professionals

(Please provide a printed copy to the clinic)

Title: Mr / Mrs / Ms / Miss (please circle one)

Full Name:

Date of Birth: / /

Address:

Post Code:

Home Phone:

Mobile:

Email:

Name & Address of Doctor:

- Are you receiving Pensioner Health Benefits? Yes / No

If yes, what is your CRN number? (on pension card)

- Are you a Veterans' Affairs cardholder? Yes / No

If yes, what is your number and type of card?

No. Gold / White

- Are you eligible for funding from any of the following schemes for your hearing?

Workcover/Workplace compensation Yes / No

If yes, in what year:

Employer Name:

- National Insurance & Disability Scheme (NDIS) Yes / No
- Home Care Package Yes / No
- Where did you hear about Hearing Professionals?

☐ Doctor ☐ Workplace ☐ Newspaper ☐ ENT/Specialist

☐ Newsletter ☐ Hearing Professionals Website

☐ Property Signage ☐ Mailout/Flyer ☐ Google

☐ Family/Friend ☐ Facebook ☐ Commonwealth HSP/DVA

☐ Email Newsletter ☐ SMS Message

Other

- Would you like to receive our Newsletter ? Yes / No

HEARING HEALTH HISTORY

Please circle all answers that apply

1. How long have you had difficulty hearing?___________

2. Have you had your hearing tested in the past? Yes / No

If yes, what was the result? ______________________

When have you last seen an audiologist/hearing care provider? _________________________________

3. Have you ever been exposed to loud noise? Yes / No

If yes, please tick what source; ☐ Musician

☐ Work/Industry Related ☐ Shooting/Firearms

Other_____________________________________

How many years total do you estimate your exposure to loud noise? _______________months / years

4. Have you worn a hearing aid before? Yes / No

If yes, please state: **Quantity**: ☐ 1 or ☐ 2

Type: ☐ Behind the Ear ☐ In the Canal ☐ In the Ear

5. Do you have a family history of hearing loss? Yes / No

If yes, please state: ☐ Mother ☐ Father ☐ Brother ☐ Sister

☐ Other Relatives____________________

6. Have you ever seen an Ear, Nose and Throat Specialist?
If yes, please state the name & address Yes / No

Please turn over and complete the reverse side

The personal health information you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care. HEARING PROFESSIONALS is committed to protecting your privacy and this information is generally only disclosed to other members of your treating team where necessary. It will however be disclosed to other organizations where required by law or if necessary for debt recovery purposes. You may gain access to information about you held by this clinic by contacting this office.

HEARING HEALTH HISTORY

7. Have you had ear surgery? Yes / No

If yes, provide details

8. Do you have arthritis in your hands or any other condition that might affect the use of a hearing aid?
If yes, please explain Yes / No

9. Do you take Blood Thinners? Yes / No

10. Do you experience any of the following in regards to your ears?

Pain / Discomfort	Yes / No	Left / Right
Discharge / Infection	Yes / No	Left / Right
Dizziness / Vertigo	Yes / No	
Numbness in the face	Yes / No	Left / Right
Sudden hearing loss	Yes / No	Left / Right
Fluctuating Hearing Loss	Yes / No	Left / Right
Ringing / Buzzing	Yes / No	Left / Right
Hole in eardrum?	Yes / No	Left / Right

11. Do you have?

Diabetes	Yes / No
HIV or AIDS	Yes / No
Haemophilia	Yes / No
Hepatitis	Yes / No

MEDICAL INFORMATION AND PRIVACY CONSENT FORM

During the course of your interactions with Hearing Professionals (HP), you will be required to disclose personal information. This personal information is required to assist us to manage your hearing health. Your personal information is protected by law, including the Privacy Act 1988 (Cth).

By signing below, I understand and provide consent to the following uses and disclosures of personal information;

- Personal information may be provided to third parties who have a direct interest in your hearing health, such as Doctors, Specialists and other Hearing Service Providers. Personal information may also be provided to (and stored by) third parties in order for us to obtain approval or vouchers from State or Commonwealth Government Agencies, such as the Office of Hearing Services or WorkSafe Victoria. The transfer of personal information to these third parties can be made by secure electronic communications or by normal Australia Post.
- Should your personal information be withheld, this may result in our inability to provide hearing services to you. For example under the Office of Hearing Services Program.
- By providing my personal information, HP can contact me by phone, email, SMS, or post information relating to my hearing health and related services.
- Personal information (hardcopy and electronic) will be stored by HP in a secure environment based in Australia.
- Personal information will not be disclosed to third parties outside of Australia, unless specifically requested by you.
- Requests for copies, complaints or alterations relating to your personal information can be made by visiting our Privacy Policy on our website at www.hearingpro.com.au.

I understand that if medical advice is needed that I should see my Medical Practitioner.

I understand that:

- Cerumen (ear wax) removal;
- Lyric fitting, removal and refitting;
- And/or Impression taking;

Involve minor risks such as small abrasions or minor bleeding.

In the event of uncommon abrasion or trauma, I will be referred to my GP or ENT for treatment. I have notified the Audiologist/Audiometrist, now present, in my complete Hearing Health History Form, of any medications or conditions that could impact this procedure.

Signature Date

Client Name

THANK YOU FOR ANSWERING THE QUESTIONS.
YOUR RESPONSES WILL ASSIST US IN PROVIDING YOU WITH THE BEST HEARING HEALTHCARE