CLIENT INFORMATION SHEET

NAME:_____ BIRTHDATE (Y/M/D): _____

MAILING ADDRESS: _____

POSTAL CODE: _____EMAIL:_____

TELEPHONE: Home: _____ Work: _____Cell: _____

HEALTH CARD or HEALTH INSURANCE PROVIDER #: _____

FAMILY PHYSICIAN : _____ CONTACT # _____

ADVOCATE or POA:_____ CONTACT # _____

HEARING AID	Right Aid	Left Aid
Manufacturer/Model		
Serial number		
Battery size		
Receiver size		
Tip description		
Mold Serial Number		
Tubing notes		
Fitting Date		
Trial Period Date		
Warranty Expiry Date		

RISK FACTORS / SPECIAL NOTES:

claustrophobia	sensitive ears	loud sounds	pressure change	drainage tube	perforation
ear drainage	chronic OM	external OM	TB, HIV, etc.	diabetes	blood thinners
tinnitus	“dizziness”/balance problems		dementia/AZ	memory loss	visual imprmt
PTSD					