The Hearing Consultancy

REGISTRATION FORM

Date:	For Office Use

CONTACT INFORMATION

First Name:	Last Name:	Title	

Address Line 1	Address Line 2	Town/City	County	Eircode/Postcode

Home Phone No:		Mobile No.:	
E-Mail:		Date of Birth	

BACKGROUND INFORMATION

Marital Status	Single, Married, Other>		
Occupation:		If Retired, Prior Occupation	
Medical Card Holder	○ Yes ○ No	PPS No:	
How did you first learn about us?:			
Other family members seen here:			

MEDICAL BACKGROUND INFORMATION

Last Hearing Test Date:	Results:	Hearing Aid User:	Right	Left	Both	Where Did You Get Your Current Aids
		○ Yes ○ No	☐	☐	☐	

Is there any family history of Hearing Problems?	○ Yes ○ No	Please provide any details e.g. Mother/Father/Siblings	

Earache of 7 days or more in last 90 days?	○ Yes ○ No	Discharge from ears in last 90 days?	○ Yes ○ No
Any Tinnitus Symptoms (Noises in the ears or head)	○ Yes ○ No	Right Ear / Left Ear / Both Ears	
Any Vertigo/Dizziness Symptoms	○ Yes ○ No		
Current Medication:			

The Hearing Consultancy respects your right to privacy and complies with the Data Protection Acts 1988 and 2003. When provided with personal data, you consent to us processing and administering such information to perform all necessary actions regarding your treatment/request. Furthermore you also consent to The Company retaining your personal data on our database for statistical/analytical and marketing purposes, we do not disclose any information to 3rd parties. You also authorise The Company to release any information required to your GP.

Audiologist Signature: _____ Client Signature: _____