

Client Details:Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Full Name: _____

Address: _____

Mobile: _____

Referring Doctor & Clinic Address: _____

Home Phone: _____

Date of Birth: _____

Postcode: _____

Email: _____

Funding Eligibility:Are you receiving Pensioner Health Benefits? ☐ Yes ☐ No If yes, CRN Number (on card): _____Do you hold a DVA Card? ☐ Yes ☐ NoCard Type: ☐ Gold ☐ White

DVA Number: _____

Are you eligible for support under any of the following?

☐ Yes ☐ NoWorkcover / Workplace Compensation: ☐ Yes ☐ NoYear of incident: _____ Employer: _____ NDIS: ☐ Yes ☐ NoHome Care Package: ☐ Yes ☐ No

How Did You Hear About Us?

☐ GP/Specialist ☐ Workplace ☐ Newspaper ☐ ENT ☐ Newsletter ☐ Website ☐ Property Signage ☐ Mailout☐ Google ☐ Family/Friend ☐ Facebook ☐ Commonwealth HSP ☐ Email Newsletter ☐ SMS Message☐ Other: _____Would you like to receive our newsletter? ☐ Yes ☐ No**Hearing Health History**

Duration of hearing difficulties: _____

Previous hearing test? ☐ Yes ☐ No

Result: _____

Last seen by Audiologist/Provider: _____

Exposure to loud noise? ☐ Yes ☐ NoSources: ☐ Musician ☐ Work/Industry ☐ Shooting/Firearms ☐ Other: _____

Approx. exposure duration: _____ months / years

Hearing aid use? ☐ Yes ☐ NoQuantity: ☐ One ☐ TwoType: ☐ Behind-the-Ear ☐ In-the-Canal ☐ In-the-EarFamily history of hearing loss? ☐ Yes ☐ NoRelation: ☐ Mother ☐ Father ☐ Sibling ☐ Other: _____Seen an ENT specialist? ☐ Yes ☐ No

Name & Clinic: _____

Additional Health InformationHistory of ear surgery? ☐ Yes ☐ No — Details: _____Arthritis or condition affecting hearing aid use? ☐ Yes ☐ No — Details: _____Taking blood thinners? ☐ Yes ☐ No

Do you experience any of the following:

Ear Pain/Discomfort ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Discharge/Infection ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Dizziness/Vertigo ☐ Yes ☐ No

Facial Numbness ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Sudden Hearing Loss ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Fluctuating Hearing ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Tinnitus (Ringing/Buzzing) ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Perforated Eardrum ☐ Yes ☐ No — Side: ☐ Left ☐ Right

Medical Conditions (tick if applicable): ☐ Diabetes ☐ HIV/AIDS ☐ Hepatitis ☐ Haemophilia

Privacy & Consent Acknowledgement

Delta Hearing collects personal and health information solely for the purpose of delivering high-quality audiology services. This data may be disclosed to your healthcare providers or relevant government agencies (e.g., Office of Hearing Services, WorkSafe) as required by law.

- I consent to Delta Hearing contacting me regarding my hearing health via phone, SMS, email, or mail.
- All personal data is stored securely in Australia and will not be shared overseas unless explicitly requested.
- I understand that I may request access to, or correction of, my records by referring to Delta Hearing's Privacy Policy on www.deltahearing.com.au.
- I acknowledge that certain procedures, such as wax removal, impression taking, or Lyric fittings, may carry minor risks (e.g., abrasions or minor bleeding), and I have disclosed any health conditions or medications that could impact this.
- Visit <https://www.deltahearing.com.au/privacy-policy> for our full Privacy Policy.

Client Name:

Signature:

Date:
