SONARIS
EAR CENTER

PATIENT INTAKE FORM

Prefix / Last Name:	First Name:	Sex:
Preferred Name:	Date of Birth:	
Address:	City: Prov:	Postal Code:
Primary Phone No.:	Secondary Phone No.:	
Email:	Occupation:	
Personal Health No.:		
Emergency Contact Name:	Relationship:	Phone:
Legal gaurdian's name(s) if patient is a child:		

Referral Source:

FAMILY DOCTOR

Full Name:	Phone:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

☐ I hereby authorize **Sonaris Ear Center to release my healthcare information to the agency and/or individuals listed below.** I have read and understood the privacy policy concerning the storage and use of my personal information:

RELEASING AGENCY/INDIVIDUAL NAME(S):

☐ I request and authorize the **agency and/or individuals listed below to release of my health care information to:** Sonaris Ear Center, 306-5050 Kingsway, Burnaby, BC, V5H 4C2.

RELEASING AGENCY/INDIVIDUAL NAME(S):

☐ I do not wish to have my health care information released to any entity. I understand that releasing my health care information to the referring entity is for my benefit and may impact future care, however, I have chosen to decline this option. The referring entity may be notified of my decision to not release my health care information.

PATIENT/LEGAL GUARDIAN SIGNATURE: **DATE:**

102-8644 120th Street, Surrey, BC V3W 3N6 | **T:** 778.564.3277 | **F:** 778.564.3278 | **E:** info@sonaris.ca
306-5050 Kingsway, Burnaby, BC V5H 4C2 | **T:** 778.564.3277 | **F:** 604.336.9093 | **E:** burnaby@sonaris.ca