HEARING TEST CONSENT FORM

Patient Information			
First Name	Last Name	Date of Birth	Gender
Street Address	City	State	Zip Code
Phone Number	Email A	ddress	Contact Preference

Primary Care Physician				
Full Name/Practice	Address	Phone Number		

I, the undersigned, consent to undergo a hearing test screening to evaluate my hearing health. I understand that the results of this test will be used for diagnostic and treatment purposes. I acknowledge that I have been provided with information about the procedure and its potential risks and benefits.

Signature Date: Signature: