



New Inductive Custom Product Order Form

*Required Fields

*Earlens Account# _____ Today's Date: _____ (mm/dd/yyyy)

*Clinic Name: _____ Ship To Address: _____

Physician Name _____ Audiologist Name: _____

*Patient Name: _____ *Date of Birth: _____ (mm/dd/yyyy)

Patient Address: _____

City: _____ State: _____ Zip: _____

Patient Email: _____ Phone: _____

☐ Concierge Opt In

Hearing Profile *(Please send an audiogram or fill in the audiometric thresholds below):*

Previous hearing aid wearer? Yes ☐ No ☐ If "yes": Style (if known): _____

Audiometric Thresholds:		250Hz	500Hz	1kHz	2kHz	4kHz	8kHz	10kHz (if available)
Air Conduction	L	_____	_____	_____	_____	_____	_____	_____
Air Conduction	R	_____	_____	_____	_____	_____	_____	_____
Bone Conduction	L	_____	_____	_____	_____	_____	_____	_____
Bone Conduction	R	_____	_____	_____	_____	_____	_____	_____
WRS - L _____ %		WRS - R _____ %						

Please allow up to 14 days for delivery of your new patient kit.

*Kit Type:

- ☐ Binaural
☐ Monaural

Stabilizer Type:

- Canal Lock
☐ Left
☐ Right

*Cable Measurement:

Descriptions	Size	Left	Right
First Blue	23	<input type="checkbox"/>	<input type="checkbox"/>
First Clear	25	<input type="checkbox"/>	<input type="checkbox"/>
Second Blue	27	<input type="checkbox"/>	<input type="checkbox"/>
Second Clear	29	<input type="checkbox"/>	<input type="checkbox"/>
Third Blue	31	<input type="checkbox"/>	<input type="checkbox"/>
Third Clear	33	<input type="checkbox"/>	<input type="checkbox"/>
Fourth Blue	35	<input type="checkbox"/>	<input type="checkbox"/>
Fourth Clear	37	<input type="checkbox"/>	<input type="checkbox"/>
Fifth Blue	39	<input type="checkbox"/>	<input type="checkbox"/>
Fifth Clear	41	<input type="checkbox"/>	<input type="checkbox"/>

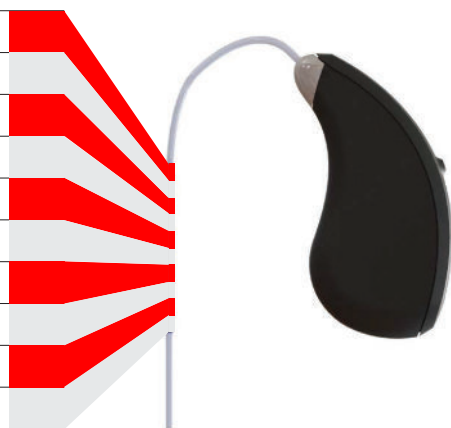
*Processor Color:

- ☐ Black
☐ Silver
☐ Champagne

Skeleton Lock

- ☐ Left
☐ Right

Other _____





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Number of Impressions*

Left _____ Right _____

Full Impression Ship Date: ____ / ____ / ____ (mm/dd/yyyy) FedEx Tracking# _____

Appointment Date for Device Placement: ____ / ____ / ____ (mm/dd/yyyy)

☐ Webinar Promotion

☐ Other Promotion _____

Additional Comments:

☐ *Earlens Premium Service Program Patient Enrollment Agreement signed by patient*

You can submit your order by emailing a scanned copy of the completed form to customercare@earlens.com or Fax to 1-844-830-9995. Once your order is received, Earlens will send you a confirmation of the order.

Please FedEx all impressions to:

Earlens Corporation, Attention: Customer Care, 1165 O'Brien Drive, Menlo Park, CA 94025, Phone (844) 234-5367

☐ *By clicking this you agree to all applicable terms and conditions. These terms and conditions can be found at www.earlens.com/salesterms*