Animas Valley Audiology

PEDIATRIC CASE HISTORY

Patient Name:_____ Date:_____

Name of person completing form:_____ Relationship to patient:_____

1. Why have you decided to have your child's hearing tested at this time? ✓ Check all that apply

❑ Suspect Hearing Loss ❑ Has a Known Hearing Loss ❑ Physician Referral ❑ Speech-Language Delay

❑ Failed Newborn Hearing Screening ❑ School Recommended ❑ Other:

2. Name, City, and State of Birthing Hospital:_____

Newborn Hearing Screening Results: ❑ Pass ❑ Fail (If failed, which ear? ❑ Right Ear ❑ Left Ear ❑ Both)

Pregnancy ❑ Healthy/normal ❑ Complications List complications?_____

Birth/Labor ❑ Healthy/normal ❑ Complications List complications?_____

Spent time in NICU? ❑ No ❑ Yes If yes, how long and what for?

Delayed developmental milestones? ❑ No ❑ Yes If yes, please explain:

History of ear infections? ❑ No ❑ Yes If yes, how many?_____ Most recent:_____

PE tubes? ❑ No ❑ Yes If yes, list the surgeon and when?

Ear-related surgery (other than PE tubes)? ❑ No ❑ Yes If yes, type, when, where?

3. Patient ❑ Currently Attends OR ❑ Is Preparing to Attend:

❑ Stays At Home With:_____

❑ Daycare: (name of center & caregiver)_____

❑ School: (school name, teacher, & grade)

4. Has your child ever been exposed to loud sounds, either recently or in the past? ❑ No ❑ Yes

If yes, please mark all that apply:

❑ Farm Equipment ❑ Music/iPod ❑ Hunting/Shooting ❑ Power Tools ❑ Motorcycles ❑ Other:

5. Does your child currently wear a hearing protection device (HPD) in the presence of loud sounds? ❑ No ❑ Yes

My child uses: ❑ Ear Muff ❑ Foam Earplugs ❑ Musician Earplugs ❑ Custom Earplugs

Are you interested in discussing custom-fit hearing protection or swim plugs today? ❑ Yes ❑ No

6. Has your child had any of the following? (mark all that apply)

❑ Deformity of the ear ❑ Drainage of the ear ❑ Head trauma

❑ Sudden or rapid loss within the past 90 days ❑ Acute or chronic dizziness ❑ Tinnitus (ringing) ❑ Ear pain

7. Has your child ever had a formal hearing evaluation? ❑ No ❑ Yes

If yes, when?_____ Where?_____ Results?_____

8. Is there any family history of hearing loss from childhood on either side? ❑ No ❑ Yes If yes, who?

9. Does your child take any prescription medications on a regular basis? ❑ No ❑ Yes If yes, please list:

Medication:_____ Condition:

10. Please check any of the following that your child currently has or has had in the past:

❑ Allergies_____	❑ Head Injury	❑ Measles	❑ Scarlet Fever
❑ Asthma	❑ Heart Condition	❑ Meningitis	❑ Sinusitis
❑ Bell's Palsy	❑ Hepatitis	❑ Mumps	❑ Vision Loss
❑ Diabetes (type?_____)	❑ HIV	❑ Neurological Disorder	❑ Other

11. Does your child currently utilize hearing aids? ❑ No ❑ Yes

If yes, when and where were they fit?_____ How many hours/day are they worn?_____

Do you have any complaints with your child's current aids? (Explain)_____

_____ _____

Parent/Guardian's Signature Date

PEDIATRIC PATIENT REGISTRATION FORM

First_____Middle Int____Last_____Prefer to be called_____
Date of Birth_____Age_____Gender_____Social Security #_____
Address (Mailing)_____City_____State_____Zip_____
Physical Address (if different than mailing)_____City_____State_____Zip_____
What School does your child attend?_____Grade_____Teacher_____
Mother's Full Name:_____Home #_____Work #_____
Cell #_____Mother's email address _____
Mother's Employer_____Occupation
Father's Full Name:_____Home #_____Work #_____
Cell #_____Father's email address_____
Father's Employer_____Occupation_____
Emergency Contact Other than parents (name & relationship)_____Phone # _____
Referred by _____
Primary Care Physician Name_____ENT's Name (if applicable) _____
How did you hear about Animas Valley Audiology Associates? (Please check one):
❑ Referred by Physician ❑ Mailer ❑ Online ❑ Referred by Friend_____
❑ Directory Plus (red book) ❑ Dex (yellow book) ❑ Newspaper Ad (paper_____) ❑ Other_____

Insurance Information ~ Please provide receptionist with card(s) to copy
(all insurance information is required at the time of service)

Primary Insurance Company_____Card Holder's Name_____
ID#_____Group ID#_____Card Holder's Social Security#_____
Cardholder's Date of Birth_____Card Holder's Relationship to the Patient_____
Primary Cardholder's Employer_____

Consents and Written Acknowledgments
(please initial and sign below)

I,_____, authorize and request my insurance company to be billed by Animas Valley Audiology Associates and pay all medical benefits due under the provision of my policy to this practice. I authorize release of medical information requested by my insurance company to process claims. I understand that I am ultimately responsible for all expenses incurred for services provided regardless of my insurance status. I consent to evaluation by Animas Valley Audiology Associates for audiologic evaluations and treatment. _____
(initial)

I authorize Animas Valley Audiology Associates to release copies of tests and audiologic reports to:

❑ Primary Care Physician listed above ❑ ENT listed above ❑ Other:_____

I,_____, acknowledge that a copy of Animas Valley Audiology Associates' Notice of Privacy Practices is available for review; I do not want a copy of it.
OR
I,_____, acknowledge that a copy of Animas Valley Audiology Associates' Notice of Privacy Practices is available for review; I have received a copy of it.

Parent's Signature:_____ Date: _____