



## 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 \_\_\_\_\_



# Animas Valley Audiology

## 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 \_\_\_\_\_  
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: \_\_\_\_\_