Davis Family Hearing

Family Audiology / Hearing Aids / Cochlear Implants / Balance / Pediatrics

Pediatric Patient Information

Childs Name: ____ Sex: Male Female

Last First M

Date of Birth: _______________________________ Social Security#___________________________

Parent/Guardians Full Legal Name & Title: ____

Address: ____

____

City State Zip Code

Email Address**:** ____

Home Phone: ____________________________ Cell Phone: _____________________________

Ok to contact about appointments/details: All Methods: Y___N___ or circle to specify: Phone/ Email/ Mail

What is the primary complaint about your child's ears or hearing? _______________________________

Name of child's physician: _________________________ How Did You Hear About Us: ________________

Date & reason for last visit: ____

Medications the child is currently taking: ____

Check if the child has ever had the following:

- ☐ Ear infection ☐ Tubes in the eardrum ☐ Excessive ear wax ☐ Asthma
- ☐ Ear pain ☐ Ringing in ears ☐ Meningitis ☐ High fever
- ☐ Dizziness ☐ Head injury ☐ Allergies ☐ Migraines
- ☐ Major medical problems (i.e., heart, lung, physical disabilities) Please explain:

  ____

Overnight stays &/or surgeries? ☐ Yes ☐ No. If yes, date & reason: ______________________________

Birth and Prenatal History

Birth weight: ______lbs _______oz Premature? ☐ Yes ☐ No

Were there any complications during pregnancy or at birth?

____

List drugs/medication taken during pregnancy:

____

Length of pregnancy: ________________Length of labor: ________________ Birth method: ________________

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At birth did the baby have the following: (please check)

Anoxia (blue color)	☐ Yes ☐ No	Respiratory distress	☐Yes ☐No
Jaundice (yellow color)	☐ Yes ☐ No	Remain in the hospital	☐ Yes ☐ No
Swallowing problems	☐ Yes ☐ No	Sucking problems	☐ Yes ☐ No

Developmental Milestones

At what age did child do the following? Sit alone______ Crawl______ Walk______

Do you have any concerns with your child's development? ☐ Yes ☐ No. If yes, explain:
____

Speech and Language

Which languages are spoken at home? ______________________________ Primary Language ____________________

At what age did child do the following? Babble: ______ Imitate sounds: ______ Say first word: ______
Use 2 to 3 word phrases: ________ Make complete sentences: ________
About how many words are in your child's vocabulary? __________
Can you understand your child's speech? ☐ Yes ☐ No
Can others understand your child's speech? ☐ Yes ☐ No Does your child follow commands and directions? Yes / No. If no, explain: ____

Hearing History

Did child pass newborn hearing screening? ☐ Yes ☐ No. If no, explain:
____

☐ The child has trouble hearing
☐ The child needs to hear instructions several times
☐ It helps the child when people speak loudly
☐ TV/radio is excessively loud
☐ Certain sounds make child uncomfortable
☐ The child "tunes in and out" of listening situations
☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school.

Are you concerned about your child's hearing? ☐ Yes ☐ No. If yes, explain:
____

Are there any family members with hearing loss? If yes, please list the family members and their ages:
____

School Information

What school does your child attend? ____
Grade ____________ Teacher _________________
Is your child having any academic trouble in school? ☐ Yes ☐ No. If yes, explain:
____
Does the child receive any special services? (i.e., speech therapy, physical therapy, occupational therapy, bilingual services, etc.)? ☐ Yes ☐ No. If yes, please explain:
____

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Insurance Information and Authorization

Co-Pay is due at time of service ☐ **No Insurance: Self Pay**

Primary Insurance
Name of
Company_______________________________________ID#_____________________________________

Secondary Insurance
Name of
Company ______________________________________ID#______________________________________

I authorize the release of any information by Davis Family Hearing to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Davis Family Hearing. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Davis Family Hearing insurance policy.

Patient/Guardian Signature ____Date _____________

Permission for Treatment

I hereby voluntarily consent to audiological care and audiological diagnostics by Davis Family Hearing deemed advisable and necessary in the diagnosis and treatment of my hearing condition.
I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient/Guardian Signature ____Date _____________

Patient Authorization Record and HIPAA Receipt

I authorize that my personal information, hearing healthcare treatment and financial information may be assessed by and disclosed to the individuals listed. (Doctor, family member, caregiver, friend) and that I have received a copy of Davis Family Hearing's Privacy Policies and understand its contents. (A full copy of our HIPAA is available upon request).

Name	Relation
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

Patient/Guardian Signature ____Date _____________