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 _____