PERSONAL HISTORY - PEDIATRIC

Today's Date:________________________

Date of Birth: ____ Age: ________________________________

Full Name:

____

Preferred Name: ____ ❑ Male ❑Female

Home Address: ____

City: ____ State: ________________ Zip: _______________

Home Phone: (____) ___________________________ Cell Phone: (____) ___________________________

E-mail Address: ____

Parent's /Guardian Name:

Name	Occupation	Age	Cell Number

Other Children in family:

Name	Age	Grade Level	Any Speech Hearing or Medical Problems?

Languages spoken at home:____

Family Physician: ___________________________ Physician Phone Number: (____) ____________________

How did you hear about our practice? ❑ Physician ❑ Counselor/Therapist ❑ School ❑ Self ❑ Friend

❑ Website ❑ Google ❑ Other: ____

What are your main concerns or reasons for this evaluation?____

____

At what age was your child's problem noted? By Whom?____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments:

- Referring Physician - ______________________________
- Primary Care Physician - ______________________________
- Other Physician - ______________________________
- Family Member (s) - ______________________________
- Other - ______________________________

MEDICAL HISTORY

Please check the following behaviors that may be pertinent to this child.

- ❑ History of hearing loss.
- ❑ Pre or Perinatal complications (i.e. low birth weight, difficulty breathing, head trauma, high fever, seizures, jaundice, etc.)
- ❑ History of allergies, asthma, reactive airway disease (RAD), frequent colds/upper respiratory infections.
- ❑ History of Attention Deficit Hyperactivity Disorder (ADHD). If so:

What age was your child diagnosed? ______________________________

Diagnosed by:____________________ Profession:________________________

Is your child receiving medication for ADHD?____________________________

How long does it take to see the medication's effect?_____________________

Has any other specialist seen your child? (Describe)

- ❑Counselor ______________________________
- ❑Psychologist ______________________________
- ❑Special Education Therapist ______________________________
- ❑Tutor ______________________________
- ❑Developmental Pediatric Specialist______________________________
- ❑Behavioral Psychologist ______________________________
- ❑Speech /Language Pathologist ______________________________
- ❑Occupational Therapist ______________________________
- ❑Physical Therapist ______________________________

Has your child or a family member been diagnosed with a learning disorder?__________________________

Has any other family member been diagnosed with ADHD or an APD? ______________________________

Please check all medical symptoms that apply:

	Left Ear	Right Ear	Both	Dates of occurrence:
Ear Pain				
Ear Infections				
Ear popping				
Ear Surgery				
Ear Tubes				
Ear Drainage				
Ears Ringing				
Trauma (Head/ Ear)				
Ear Deformity				
Dizziness or unsteadiness				

Has your child had had any of the following? Please check all of those that apply.

- ❑ Fetal Alcohol Syndrome
- ❑ Depression/Anxiety
- ❑ Craniofacial abnormality
- ❑ Ototoxic Medication
- ❑ Fever over 104
- ❑ Asphyxia
- ❑ Head/Neck Deformity
- ❑ Syndrome abnormality
- ❑ Mechanical ventilation
- ❑ Other_____________________
- ❑ Hyperbilirubinemia
- ❑ CMV
- ❑ Bacterial Meningitis
- ❑ Maternal Substance abuse
- ❑ Other_____________________

If checked above please describe:____

____

Please check all medical symptoms and conditions that apply:	YES	NO
Eye problems (such as blurred or double vision or pain)		
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)		
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)		
Respiratory issues (such as shortness of breath, cough, wheezing		
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):		
Musculoskeletal issues (such as joint pain, swelling, recent trauma)		
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):		
Psychiatric issues (such as depression, anxiety, compulsions)		
Endocrine symptoms (such as frequent urination, hot flashes)		
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)		
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)		

List any operations ____

Other chronic illnesses ____

Any drug or other allergies (including latex/plastics)______________________________________

Please list all current medications or attach a list:

NAME	DOSE (MG)	FREQUENCY (Example: 1 a day)	DELIVERY METHOD (Example: Oral , Shot, Eye drops)

Has your child taken medication today?____

____

Today's Date:________________________________

Full Name: ____
Date of Birth: ____ Age: _________________________________

HEARING LOSS HISTORY - PEDIATRIC

Do you think your child has hearing loss? ❑Yes ❑ No

Does your child complain of noise in the ears or head? ❑Yes ❑ No

If yes, please describe concerns: ____

____

Does your child have dizziness or imbalance? ❑Yes ❑ No

Did you child have a hearing screening as a newborn? ❑Yes ❑ No

If yes, what was the outcome? ❑Pass ❑Fail

What age did you child speak their first words? ____

Do you feel your child is developing speech & language skills normally? ❑Yes ❑ No

Age of first ear infection diagnosed by doctor:____

Number of ear infections: Aged 0 to 2____; Aged 2 to 4 ____; Aged 4 to 6_____

Last ear infection: Date___________ Age__________

Does your child currently have ventilation tubes? ❑Yes ❑ No

Has your child had any ear surgeries? ❑Yes ❑ No

If yes, please describe ____

____

Do you have any other concerns about your child's hearing? ❑Yes ❑ No

If yes, please describe concerns: ____

____

Have any family members or your child's teacher, expressed concerns about their hearing? ❑Yes ❑ No

If yes, please describe concerns: ____

____

Do any of your child's relative have hearing problems? ❑Yes ❑ No

If yes, please describe who and at what age it was identified______________________________________

____

Does your child wear hearing aids? ❑Yes ❑ No

If yes, where were they fit: ____

How many hours per day does your child use hearing aids? ____

Benefit: ❑Good ❑Fair ❑Marginal

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Acknowledgement

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Audiology & Hearing Services of Charlotte, PLLC.*

_____ **(initial here) HIPPA Acknowledgement:** By initialing this section and signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC*'s notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ **(initial here) Participation in Insurance Products:** By initialing this section and signing below, I relieve *Audiology & Hearing Services of Charlotte, PLLC* of any responsibility in reference to nonparticipation in the insurance or if my services were to be performed by another entity.

_____ **(initial here)Release of Information:** By initialing this section and signing below, I give permission to *Audiology & Hearing Services of Charlotte, PLLC* to disclose all or any part of my medical records to any of my other treating health care providers as needed for treatment purposes. *Audiology & Hearing Services of Charlotte, PLLC* will release information as permitted by law and/or HIPPA regulations.

_____ **(initial here) Educational and/or Marketing Information:** By initialing this section and signing below, I authorize *Audiology & Hearing Services of Charlotte, PLLC* to send me educational and/or marketing information on the products and services offered by *Audiology & Hearing Services of Charlotte, PLLC*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ **(initial here) Financial Responsibility** By initialing this section and signing below, I agree to accept the financial policies of *Audiology & Hearing Services of Charlotte, PLLC*. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Printed Name:____

Signature of Patient or Guardian: ____

Date: __________________

Late Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way.
However, if you are more than 15 minutes late you will have to reschedule your appointment and will be considered a "No-Show".

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24-hour notice is $25.00, which will be charged to your account and is not payable by any insurance company.

Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:
□ I have been informed of and understand the Clinic's late policy.
□ I have been informed of and understand the Audiology & Hearing Services of Charlotte No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a $25.00 Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: ______________________________________ Date:___________________