CENTRAL OREGON AUDIOLOGY & HEARING AID CLINIC

Pediatric Patient Information

Patient Information: **Today's Date: _____**

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ [ ] Male [ ] Female

Primary Care Doctor: _____ Phone: _____

Mailing address: _____ City _____ Zip _____

Mother/Guardian Name: _____ Phone: _____

Father/Guardian Name: _____ Phone: _____

Primary Insurance Information:

Insurance Name: _____ Policy #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Name of Employer who policy is through: _____

Secondary Insurance Information:

Insurance Name: _____ Policy #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Name of Employer who policy is through: _____

Financial Agreement:

This office, as a courtesy, bills primary insurance carriers. If payment is denied, or not received from my insurance company, I understand that I will be responsible for any outstanding balance.

I authorize payment from my insurance company to be made directly to Central Oregon Audiology. I also authorize this clinic to submit reports or copies of my medical records to my insurance company if needed to support or verify a claim.

Printed Name: _____ Signature: _____

Relationship to Patient: _____Date: _____

Notice of Privacy Practices:

Please sign below acknowledging that you have been offered an opportunity to review a copy of our HIPPA Notice of Privacy Practices. You are entitled to a personal copy at any time to keep for your records.

Printed Name: _____ Signature: _____

Relationship to Patient: _____Date: _____

HIPPA Consent to Leave Voicemail/Message

I give permission to leave relevant medical information on my answering machine or voicemail. I will allow relevant medical information to be shared with the person who may answer my telephone.

Printed Name: _____ Signature: _____

Relationship to Patient: _____Date: _____

Pediatric Medical History

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____

Do you think your child has a hearing problem? □ Yes □ No

Does your newborn startle at loud sounds? □ Yes □ No

Has your child had any earaches? □ Yes □ No

If so, which ear(s)? □ Left □ Right □ Both

Have their ears been medically treated? □ Yes □ No

If so, which ear(s)? □ Left □ Right □ Both

Did your child pass a newborn hearing screening? □ Yes □ No

If no, which ear failed? □ Right □ Left □ Both

Did your child have an infection at birth? □ Yes □ No

If yes, what type: □ Cytomegalovirus □ Rubella □ Herpes □ Syphilis □ Toxoplasmosis

□ Other _____

Did your child have asphyxia or breathing problems at birth? □ Yes □ No

Were any blood transfusions given? □ Yes □ No

Was your child in intensive-care unit? □ Yes □ No

Were there any congenital malformations involving the head, neck or ears? □ Yes □ No

Was your child born prematurely? □ Yes □ No

If so, how many weeks? _____

Was your child treated with antibiotics? □ Yes □ No

If so, what kind? _____

Did your child ever have meningitis? □ Yes □ No

If so, what age? _____

Did your child have elevated bilirubin (jaundice)? □ Yes □ No

Is there a family history of hearing problems in early childhood? □ Yes □ No

If so, what relationship to child? _____

Does your child have any other associated disability? □ Yes □ No

□ Blindness or other vision disorder □ Cerebral palsy □ Developmental disability

□ Seizure disorder □ Down syndrome □ Learning disability □ Other _____

Is your child receiving any medication? □ Yes □ No

If so, please list name of medication and what it is taken for:

_____ _____

_____ _____