Pediatric Patient Intake

Under 18 years of age

HearingLife

Patient

Today's Date: / / Gender: ☐ Male ☐ Female ☐ Other

Name: Date of Birth: / /

Address:

City: State: Zip:

Pediatrician: Referring Doctor:

Birth Hospital:

School Information

Name: Grade:

Special Services Received:

Services Provided by:

Does your child currently have an IEP (Individualized Education Plan)? ☐ Yes ☐ No

If yes, please describe:

Guardian

Guardian Name: Guardian Phone: ( )

Email:

Phone: Primary ( ) Secondary ( )

Insurance

Primary Insurance

Can be found on the back of your insurance card.

Primary Insurance Company Phone Number ( ) Member ID#

Name of Policyholder Policyholder Date of Birth / /

Secondary Insurance

Secondary Insurance Company Phone Number ( ) Member ID#

Name of Policyholder Policyholder Date of Birth / /

Pediatric Birth History

HearingLife

Patient

Name: _____ Date: / /

Birth History

What is the reason for today's visit?_____

Did the child's mother experience any complications/illness during pregnancy? ☐ Yes ☐ No

If yes, please describe:_____

_____

Length of Pregnancy_____ Child's Birth Weight_____

Was the child in the NICU (Neonatal Intensive Care Unit)? ☐ Yes ☐ No

If yes, How long was the child in the NICU?_____

Did your child receive oxygen? ☐ Yes ☐ No

If yes, for how long?_____

Did you child receive any known medications/treatments while in the NICU? ☐ Yes ☐ No

If yes, please list:_____

Please check any conditions that were present at the time of your child's birth:

☐ Jaundice	☐ Toxoplasmosis	☐ Seizures
☐ Breathing problems	☐ Herpes Simplex	☐ Rubella
☐ Blood exchange	☐ Hyperbilirubinemia	☐ Syphilis
☐ Cytomegalovirus (CMV)	☐ Other:_____	

Please check if your child has experienced any of the following illnesses or conditions:

☐ Allergies	☐ Asthma	☐ Colds	☐ Tonsillitis	☐ Influenza
☐ Headaches	☐ Dizziness	☐ Tinnitus	☐ Sinusitis	☐ Meningitis
☐ Pneumonia	☐ Convulsions	☐ Croup	☐ Chicken Pox	☐ Head Injury
☐ Encephalitis	☐ Measles	☐ Mumps	☐ German Measles	☐ Mastoiditis
☐ High Fevers	☐ Ear Infections	☐ Draining Ears	☐ Other:_____	

Pediatric Medical History

HearingLife

Patient

Name: _____ Date: / /

Medical History

Did your child pass their newborn hearing screening at birth? ☐ Yes ☐ No

If no, was follow-up testing pursued? ☐ Yes ☐ No

Has your child received light therapy? ☐ Yes ☐ No

If so, please describe:_____

Had your child been diagnosed with a syndrome? ☐ Yes ☐ No

If so, please describe:_____

Does your child have vision impairment? ☐ Yes ☐ No

If so, please describe:_____

Has your child experienced ear infections in the past? ☐ Yes ☐ No

If yes, how often were they treated with antibiotics?_____

Has your child received PE tubes? ☐ Yes ☐ No

If yes, when were they placed?_____

Are they still in place? ☐ Yes ☐ No

How many sets of tubes?_____

Has your child ever received a hearing test? ☐ Yes ☐ No

If yes, where and what results were obtained?_____

Has your child ever had ear surgery? ☐ Yes ☐ No

If yes, where and what results were obtained?_____

Has your child been hospitalized? ☐ Yes ☐ No

If so, please describe:_____

Has your child ever received a speech/language evaluation? ☐ Yes ☐ No

If yes, where and what results were obtained:_____

Primary language in the home:_____

Is your child currently on medication? ☐ Yes ☐ No

If so, please describe:_____

Is there a family history of hearing loss? ☐ Yes ☐ No

If so, please describe:_____

Do you suspect that your child has a hearing loss? ☐ Yes ☐ No

Are you concerned regarding your child's speech production abilities? ☐ Yes ☐ No

Has your child ever received services through Early Intervention (EI)? ☐ Yes ☐ No

If yes, what services?_____

Acknowledgements/Consents

HearingLife

Patient

Name: _____ Date: / /

Acknowledgement of Receipt of Privacy Practices Notice

_____ ***Initials***

I acknowledge receipt of the Notice of Privacy Practices from your company. The Notice of Privacy Practices provides information about how HearingLife may use and disclose your protected health information. HearingLife encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by contacting us at the address below or visiting the website www.hearinglife.com.

Consent to Telephone Contact

_____ ***Initials***

I hereby give my consent for your company, or entities calling on its behalf, to call my home or other alternative locations and leave a message on voice mail or in person in reference to carrying out treatment, payment, or operational activities such as appointment reminders, insurance items and any calls pertaining to my hearing health care. This permission shall remain in effect as long as I have not revoked my consent in writing and asked to be placed on your company's do-not-call list. Signing this form does NOT obligate me to make any purchases or otherwise respond to calls from your company.

Please fill in the phone number(s) we have your permission to use to contact you.

Phone: Home ( ) Cell ( )

Authorization for Telehealth Services and Use or Disclosure of Patient Photographic and/or Video Images

_____ ***Initials***

Telehealth allows a hearing care provider to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in hearing care via Telehealth. I understand that the information shared or transmitted via Telehealth is protected by the same confidentiality laws that protect my medical information for in-person treatment. Not all video or image transmissions are recorded and stored. Video or images collected during the Telehealth visit may be used for treatment and training purposes. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Authorization to Release Protected Health Information

_____ ***Initials***

Many of our patients allow family members, such as their spouse or children, to call and request medical or billing information. Under privacy laws, we are not allowed to give this information to anyone without your consent. If you wish to have your medical or billing information released to family members you must authorize this disclosure and initial. I authorize HearingLife to release my medical and/ or billing information to the following individual(s):

Name: _____ Relationship: _____

Phone: _____

I understand I have the right to revoke this authorization at any time by contacting HearingLife. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclose by the above recipient.

I acknowledge and consent to the initialed sections above:

_____ / /

Guardian Signature ***Date***