Child Registration Form

Please print clearly   Today's Date: ____ / ____ / _____

PATIENT INFORMATION:

First Name: ________________________________ MI: _________ Last Name: ______________________________

Preferred Name: ____________________________

Address: __________________________________ City: ________________ State: ________ Zip Code: ____________

Date of Birth: ____ / ____ / _____   Gender: M / F   E-mail: ____

Phone: ____________________ (Home/work/cell) ○ Please check the best number to reach you
____________________ (Home/work/cell) ○

Mother and Fathers full name(s): ____

Guardian/Caregiver: _______________________________________   Relationship: ____________________

REFERRAL INFORMATION:

Referring doctor: ____

Signature for release of information (to the above mentioned provider): ________________________________

PAYMENT INFORMATION: Patient is responsible for payment at time of service.

Insurance information must be filled out for Medicaid, Medicare and Tricare patients.

Do you have Medicaid: Y   N   If yes, Medicaid #: ____________________

Do you have Medicare: Y   N   If yes, Medicare #: ____________________

Primary Insurance: ___________________________________ ID#: _________________________

Sponsor: _________________________ DOB: ________________ Relationship: _______________________

Secondary Insurance: _________________________________ ID#: ___________________________

Sponsor: _________________________ DOB: ________________ Relationship: _______________________

TRICARE ONLY

*Sponsor name: ____________________________________ SS#: __________________ DOB: _______________

Child History Form (birth to 16yrs)

PATIENT NAME: ____

PARENT/GUARDIAN NAME: ____

Primary complaint/concern: ____

Where was your child born (city/state)? ____

Name of birth hospital: ____

Was your child full term (36-40 weeks)? Or premature (<36 weeks)? _______________________________

If premature, how many weeks? ________________________

Were there any complications with the birth? Yes No

If yes, please explain: ____

Was your child hospitalized after birth? Yes No

If yes, why and for how long? ____

Was your child's hearing screened at birth? Yes No

If yes, what were the results? Pass Refer

How many ear infections did your child have prior to the age of one? _______________________________

How many ear infections to date? ____

Has your child had ear problems in the last 6 months? Yes No

Has your child been evaluated by an ENT? Yes No

If yes, who did they see and when? ____

Has your child had ear tubes? Yes No

If yes, how many times? ____

Is there a family history of hearing loss? Yes No

If yes, please explain: ____

Does your child have frequent colds, problems with sinuses and/or allergies? Yes No

If yes, please explain: ____

Please list any medications your child is taking: ____

____

How does your child communicate (ex: pointing, gestures, words, sentences.) _________________________

____

Do you have concerns about speech and language development? Yes No

If yes, please explain: ____

Does your child attend daycare, preschool or public/private school? Yes No

If yes, where? ____ How often? ______________________________

Do the teachers or caregivers have concerns? Yes No

If yes, please explain: ____

How does your child do in school? ____

Do you think your child has hearing difficulty? Yes No Sometimes

If yes, please explain: ____

Do you have any concerns with your child's vision? Yes No

If yes, please explain: ____

Is your child receiving any kind of services (ex. Occupational therapy, physical therapy, speech therapy) Yes No

If yes, where? ____

By whom? ____ How often? __________________________

Does your child currently wear hearing aids? Yes No

If yes: Make: _______________________ Model: ____________________________

Year Purchased: _______________ Bought where?______________________

Has your child been diagnosed with any pre-existing conditions? (Circle any that apply)

Down syndrome	Cleft lip/palate	Autism/PDD	
Usher syndrome	Waardenburg syndrome	Cytomegalovirus (CMV)	Alport syndrome
Stickler syndrome	Congenital Syphilis	Leukemia	Muscular Dystrophy
ADD/ADHD	Fetal Alcohol Syndrome	Sickle Cell Anemia	Cerebral Palsy (CP)
None	Other: _______________________________________		

Is there any other information we should know? ____

____

Signature: ____ Date: ___________

(Please note: All information is completely confidential and available only per release of the patient.)

ACKNOWLEDGMENET OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse this acknowledgement)

I have had an opportunity to review or have received a copy of Northern Hearing Services, Inc.'s "Notice of Privacy Practices" documents.

____

Please print patient name

____

Signature of patient, parent of guardian   Date

____

OFFICE USE ONLY

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign acknowledgement

_______ Communication barrier prohibited obtained the acknowledgment

_______ An emergency situation prevented us from obtaining acknowledgment

_______ Other (specify below)

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