Pediatric Registration Form

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

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Primary Phone #: (_____)_____-_____ (Home / Work / Cell)

Secondary Phone #: (_____)_____-_____ (Home / Work / Cell)

Preferred method of contact: Phone Text message

Mother and Father's full name(s): _____

Guardian/Caregiver: _____ Relationship: _____

Phone Number: (_____)_____-_____

REFERRAL INFORMATION:

Referring Physician: _____

PAYMENT INFORMATION: Patient is responsible for payment at today's visit. We will bill insurance as a courtesy.

Copies of insurance cards are required for ALL insurance companies through which you have coverage, including Medicare.

- ☐ **Tricare Insurance Holders**
  Sponsor's Name: _____ DOB: _____ SSN#: _____
  Address (if different than above): _____

- ☐ **Primary Insurance Holders**
  Sponsor's Name: _____ DOB: _____ Relationship: _____

- ☐ **Private Insurance Holders**
  Sponsor's Name: _____ DOB: _____ Relationship: _____

By signing below, I certify all information is true and correct to the best of my knowledge.

X_____ **Date Signed: _____**

Infant Case History Form (birth to 6 months)

PATIENT NAME: _____

PARENT/GUARDIAN NAME: _____

Reason for visit: _____

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

Name of birth hospital or center: _____

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

If premature, how many weeks? _____

Were there any complications throughout pregnancy? Yes No

If yes, please explain: _____

Were there any complications with the birth? Yes No

If yes, please explain: _____

Was your child hospitalized (NICU) after birth? Yes No

If yes, why and for how long? _____

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

If yes: Right ear results _____ Left ear results _____

Is there a family history of hearing loss (present at birth)? Yes No

If yes, please explain: _____

Were any of the following present at birth? (Circle any that apply)

Low birth weight Difficulty gaining weight Difficulty breathing Jaundice

Has your child been diagnosed with any of the following conditions? (Circle any that apply)

Cytomegalovirus (CMV)	Cleft lip/palate	Congenital Syphilis
Down syndrome	Waardenburg syndrome	Branchio-oto-renal syndrome
Usher syndrome	Fetal Alcohol Syndrome	CHARGE syndrome
Stickler syndrome	Alport syndrome	Charcot-Marie-Tooth syndrome
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.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse this acknowledgement)

PATIENT NAME: _____ DATE: _____

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

I authorize Northern Hearing Services, Inc. to discuss my health information with the individual(s) listed below:

_____ relationship: _____

_____ relationship: _____

_____ relationship: _____

_____ _____

Signature Printed name

_____

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 obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining the acknowledgment

_____ Other: _____

REVISED 04.2022