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: _____**

Pediatric History Form (6 mo through 17 yrs)

Patient Name: _____

Primary complaint/concern: _____

Name of birth hospital: _____

If out of town, city/state: _____

Gestational age at birth (please circle): Full term (36-40 weeks) Premature (<36 weeks)

If premature, how many weeks? _____

Were there any complications during pregnancy and/or birth? Yes No

If yes, please explain: _____

Was patient hospitalized after birth? Yes No

If yes, why and for how long? _____

Universal Newborn Hearing screening results (please circle): Left ear: pass / refer Right ear: pass / refer

☐ Was not screened

How many ear infections did patient have prior to age of one? _____

How many ear infections to date? _____

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

Has patient been evaluated by ENT? Yes No

If yes, who did they see and when? _____

History of ear tubes? Yes No

If yes, how many times? _____

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

If yes, please explain: _____

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

If yes, please explain: _____

Please list any medications patient is taking: _____

_____

Do you have concerns with patient's vision? Yes No

Do you think patient has hearing difficulties? Yes No Sometimes

If yes, please explain: _____

Does patient currently wear hearing devices? Yes No

If yes: Make: _____ Model: _____

Year purchased: _____ Place of purchase: _____

Do you have concerns with patient's speech and language development? Yes No

If yes, please explain: _____

How does patient communicate (i.e., pointing, gestures, words, sentences)? _____

_____

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

If yes, where? _____ How often? _____

Do teachers/other caregivers have any concerns? Yes No

If yes, please explain: _____

Is patient receiving any services (i.e. occupational therapy, physical therapy, speech therapy)? Yes No

If yes, where? _____

By whom? _____ How often? _____

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

Down syndrome	Cleft lip/palate	ADD/ADHD
Usher syndrome	Autism	Fetal Alcohol Syndrome
Stickler syndrome	Congenital Syphilis	Muscular Dystrophy
Waardenburg syndrome	Cytomegalovirus (CMV)	Cerebral Palsy (CP)
Alport syndrome	Leukemia	Sickle Cell Anemia
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: _____

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