AUDIOLOGY ASSOCIATES OF DFW

3132 Matlock Rd #303
Arlington, TX 76015
817.472.7720

610 Uptown Blvd #2000
Cedar Hill, TX 75104
817.504.3644

Child Patient Information

Date:_____

Name:_____
First Middle Last

Preferred name:_____

Address:_____
Street City State Zip

Date of Birth:_____Age:_____Gender:_____

Preferred phone:_____2nd phone:_____Other phone:_____

Can messages be left at all phone numbers?_____If not, please specify:_____

Email address:_____Would you like to receive occasional mail or email with hearing technology updates from Audiology Associates of DFW?_____

Who referred you to our office?_____

Who does the child live with:_____

Pediatrician:_____Phone number:_____

Address:_____

What is the reason for your visit today?_____

Primary Insurance:_____

Policy holder name:_____Policy holder birthdate:_____

Relationship to policy holder:_____

Secondary Insurance:_____

Policy holder name:_____Policy holder birthdate:_____

Relationship to policy holder:_____

Medical History

Please circle any of the following child currently has or had in the past:

Ear infections	Speech/language delay	Dizziness
Ear pain	Speech therapy	Meningitis
Ear drainage	Ear tubes	Sensitivity to sounds
Ear fullness	Ringing/noises in ears	Fluctuating hearing

Please list (or attach a list) of current medications and why they were prescribed:_____

_____

History of ear surgeries?_____If yes, when and what was the procedure?_____

_____Any complications during pregnancy or at birth?_____

_____

Any physical limitations or developmental delays?_____

Has your child been evaluated by: Speech-Language Pathologist?_____Ear, Nose, Throat doctor?_____

If yes to above, please list names:_____

History of exposure to loud noise?_____If yes, describe:_____

Family history of hearing loss?_____Date(s) of previous hearing tests?_____

When did you first notice the hearing loss?_____Was it sudden or gradual? (circle one)

Which ear hears better (circle one): Right Left Same

When does the child have difficulty hearing (circle all that apply):

In quiet	Noisy Places	TV/Radio	Church
School	Telephone	Groups	Other:_____

Does your child (circle all that apply):

Rely on others to "translate"	Hear but not understand
Consistently respond to speech	Turn head to locate a sound

Did you child pass the newborn hearing screening?_____

If child is currently wearing a hearing aid or has in the past please answer the following:

Which ear aided:_____Brand:_____Style:_____
Age of hearing aid(s):_____How often do you wear it:_____
Where was it purchased:_____
What would you like to improve about your child's current hearing aids:_____

_____

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PLEASE SIGN YOUR INITIALS BY EACH STATEMENT TO CONFIRM YOUR AGREEMENT AND SIGN AND DATE AT THE BOTTOM.

CONSENT FOR AUDIOLOGICAL SERVICES

_____ I consent to receive Audiological services at Audiology Associates of DFW. This consent encompasses Audiological procedures including, but not limited to, diagnostic testing, and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive Audiological care at Audiology Associates of DFW.

PAYMENT & INSURANCE BENEFITS

_____ I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

_____ **If providing insurance,** I authorize release of medical information for my insurance claims to my insurance company and its utilization review. This potentially may include information about psychiatric conditions, alcohol and drug use, sickle cell anemia, or aids, depending upon the contents of my records. **NOTE: Without this release it is not possible to file insurance claims.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have been made available a copy of Audiology Associates of DFW's Notice of Patient Privacy Practices.

Guardian Signature: _____Date:_____

PATIENT AUTHORIZATION OF DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means. The patient may revoke or change this authorization at any time with a written request.

Please indicate any other persons with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care:

Name: _____ Relationship_____Phone#_____

Name: _____ Relationship_____Phone:_____

Guardian Signature:

_____Date:_____