Hearing Associates of Dothan, LLC
Pediatric Patient Registration Form

New patient registration
Update of current patient demographic information

Demographic Information

Patient Name: ____ **Today's Date:** __________________

Street Address, City, State, Zip Code: ____

Home Phone: ________________ **Work Phone:** ___________________ **Cell Phone #:** __________________

E-mail Address: ____ **Spoken Language:** English Spanish Other

Date of Birth: ________________ **Social Security Number:** ______________________ **Gender:** Male or Female

Marital Status: Single Married Divorced Widowed **Name of Spouse, if applicable:** ________________________

Employer: _______________________________________ Part-Time Full-Time Retired

Occupation: ____________________________________

Emergency Contact: ___________________ **Relationship to Patient:** _____________ **Phone #:** _____________

Primary Insurance: ________________________**Secondary Insurance:** _______________________________

Responsible Party/Name of Insured (if different than above): ____

Social Security Number of Responsible Party/Insured: ____

Date of Birth of Responsible Party/Insured: __________________

Address, if different: ____

Referring Physician Name: ______________________________________ **Phone #:** ______________________

Primary Care Physician Name: ___________________________________ **Phone#:** ______________________

We will send a copy of your test results and/or report to your referring or ordering physician. If you would like for any additional physicians and/or other entities to receive a copy of your tests and/or report, please notify our receptionist and fill out a records release.

How did you hear about us? (*Please check <u>all</u> that apply*):

_____ Phone book	_____ Sign	_____ Internet	_____ Health Fair
_____ Family Member	_____ Doctor	_____ Direct Mail Piece	_____ Open House
_____ Website	_____ Friend	_____ Newspaper	_____ Facebook
_____ Other: ___________			

We will make a copy of the front and back of your insurance cards for our records.

Allergies (food, medications, plastics, etc.): ____

Current Medications (drug name, dosage, frequency and method):

____

____

See other side

Has your child experienced any of the following major medical conditions:

_____ AIDS/HIV	_____ Cerebral Palsy	_____ Heart Problems	_____ Schizophrenia
_____ Autism	_____ Chicken Pox	_____ Kidney Disease	_____ Seizure Disorder
_____ Aspergers/PDD	_____ Diabetes	_____ Measles	_____ Speech/Lang Delay
_____ ADD/ADHD	_____ Encephalitis	_____ Meningitis	_____ Thyroid Disorder
_____ Bipolar Disorder	_____ Genetic Disorders	_____ Multiple Sclerosis	_____ Visual Deficit
_____ Cancer	_____ Head Injury	_____ Obsessive Compulsive	_____ Other: ______________

Was your child born full term? Yes or No **If No, when? ____**

What was your child's birth weight? _________________

Did you experience any of the following complications during pregnancy:

_____ **Illness, fever, pneumonia, or flu like symptoms**
_____ **Exposure to alcohol**
_____ **Exposure to drugs (prescription, illegal, other)**
_____ **Exposure to smoking**
_____ **High Blood Pressure**
_____ **Stress/Anxiety**
_____ **Pre-eclampsia**

Did your child experience or require any of the following after delivery:

_____ Need for Oxygen	If checked, please state how many days/weeks? ___________________________
_____ Need for IV antibiotics	If checked, please list the name of antibiotics ______________________________
	If checked, please state how many days/weeks? ___________________________
_____ Jaundice	If checked, did your child receive phototherapy? Yes or No
	If checked, did your child receive any blood transfusions? Yes or No

Please check <u>all</u> medical conditions that apply:

_____ Vertigo, Dizziness, or Unsteadiness	*If checked, is it accompanied by: Vomiting Nausea Ear Noises*
_____ Ear Deformity	*If checked, Right ear Left Ear Both ears*
_____ Ear Drainage (past 90 days)	*If checked, Right ear Left Ear Both ears*
_____ Ear Pain or Discomfort	*If checked, Right ear Left Ear Both ears*
_____ Family History of Hearing Loss	*If checked, who?* ____
_____ History of Ear Infections	*If checked, Right ear Left Ear Both ears If so, when?* _________________
_____ History of Ear Wax Buildup	
_____ History of Noise Exposure	*If checked, please describe?* ____
_____ Hypersensitivity to Sounds	*If checked, please describe?* ____
_____ Previous Ear Surgery	*If checked, Right ear Left Ear Both ears If so, when?* _________________
_____ Tinnitus/Ringing/Noises in ears	*If checked, Right ear Left Ear Both ears Frequency?* ___________________
_____ Other:	*Please describe:*____

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of Hearing Associates of Dothan, LLC's Notice of Privacy Practices. The Notice provides information about how we may use and disclose health information for the purposes of treatment and/or payment; purposes for other than treatment and health care operations; and shared as required/permitted by law. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

______ (initial here) I authorize Hearing Associates of Dothan to market/contact me regarding new services and/or treatment options that may further educate me regarding my hearing health.

_____ (initial here) By initialing this section and signing below, I agree to accept financial responsibility for all charges for services rendered to me by Hearing Associates of Dothan, LLC and/or which are not covered by my insurance plan. Payment in full is due on the date of service.

Signature of Patient or Guarantor: ____ Date: ____________________