

Hearing Associates of Dothan, LLC

Pediatric APD 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 complete a records release.

How did you hear about us? (Please check all that apply):

<input type="checkbox"/> Phone book	<input type="checkbox"/> Sign	<input type="checkbox"/> Internet	<input type="checkbox"/> Health Fair
<input type="checkbox"/> Family Member	<input type="checkbox"/> Doctor	<input type="checkbox"/> Direct Mail Piece	<input type="checkbox"/> Open House
<input type="checkbox"/> Website	<input type="checkbox"/> Friend	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Facebook
<input type="checkbox"/> Other: _____			

WE WILL MAKE A COPY OF THE FRONT/ BACK OF YOUR INSURANCE CARDS FOR OUR RECORDS

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

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

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

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

If your child takes medication for ADD/ADHD, did he/she take their medication this morning? _____

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:

- | | |
|---|--|
| <input type="checkbox"/> Illness, fever, pneumonia, or flu like symptoms | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Exposure to alcohol | <input type="checkbox"/> Stress/Anxiety |
| <input type="checkbox"/> Exposure to drugs (prescription, illegal, other) | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Exposure to smoking | |

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

- | | |
|--|--|
| <input type="checkbox"/> Need for Oxygen | If checked, please state how many days/weeks? _____ |
| <input type="checkbox"/> Need for IV antibiotics | If checked, please list the name of antibiotics _____ |
| | If checked, please state how many days/weeks? _____ |
| <input type="checkbox"/> 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 all medical conditions that apply:

- | | |
|---|---|
| <input type="checkbox"/> Vertigo, Dizziness or Unsteadiness | <i>If checked, is it accompanied by: Vomiting Nausea Ear Noises</i> |
| <input type="checkbox"/> Ear Deformity | <i>If checked, Right ear Left Ear Both ears</i> |
| <input type="checkbox"/> Ear Drainage (Past 90 days) | <i>If checked, Right ear Left Ear Both ears</i> |
| <input type="checkbox"/> Ear Pain or Discomfort | <i>If checked, Right ear Left Ear Both ears</i> |
| <input type="checkbox"/> Family History of Hearing Loss | <i>If checked, who? _____</i> |
| <input type="checkbox"/> History of Ear Infections | <i>If checked, Right ear Left Ear Both ears If so, when? _____</i> |
| <input type="checkbox"/> History of Ear Wax Buildup | |
| <input type="checkbox"/> History of Hearing Loss | <i>If checked, which ear? _____ Gradual Sudden Fluctuating</i> |
| <input type="checkbox"/> Hypersensitivity to Sounds | <i>If checked, please describe? _____</i> |
| <input type="checkbox"/> Previous Ear Surgery | <i>If checked, Right ear Left Ear Both ears If so, when? _____</i> |
| <input type="checkbox"/> Tinnitus/Ringing/Noises in ears | <i>If checked, Right ear Left Ear Both ears Frequency? _____</i> |
| <input type="checkbox"/> Other: | <i>Please describe: _____</i> |

Educational and Therapy History

Where does your child attend school? _____ Grade: _____

Does your child receive special education services? _____

If yes, please explain what services he/she is receiving: _____

Does your child receive speech and/or language therapy? _____

If yes, where? _____

How many times per week? _____

Does your child receive occupational therapy? _____

If yes, where? _____

How many times per week? _____

Does your child receive vision therapy? _____

If yes, where? _____

How many times per week? _____

Does your child receive ABA therapy? _____

If yes, where? _____

How many times per week? _____

Has your child completed any listening programs? _____

If yes, where? _____

How many times per week? _____

Listening Skills

1. Does your child say "huh" or "what" frequently? _____
2. Does your child frequently ask for directions to be repeated? _____
3. Does your child respond in a slow or delayed manner? _____
4. Does your child often misunderstand what is said? _____
5. Does your child appear as though he/she is not paying attention? _____
6. Does your child have a low tolerance for noise? _____
7. Does your child seem sensitive to loud sounds? _____
8. Is your child easily distracted in noisy environments? _____
9. Does your child have difficulty comprehending lengthy/complex information?

10. Does your child often "hear" a similar word (bath vs. math)? _____

Academic Skills

1. Is your child's academic performance inconsistent? _____
2. What academic areas does your child struggle with?

3. Does your child rush through homework or class work without realizing that errors were made?

4. Is your child motivated to learn new concepts? _____
5. Does your child perform well in a one-to-one situation? _____
6. Does your child improve in performance when in a structured environment?

7. Does your child display weak reading, writing or spelling skills?

8. Does your child have difficulty explaining a story or idea?

9. Does your child have difficulty completing a task or display poor organizational skills?

Other Information

Please discuss any additional information that might be helpful

_____ (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: _____