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

How would you like to be contacted regarding appointments? ☐ Call ☐ Text ☐ E-mail

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*):

_____ 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/ BACK OF YOUR INSURANCE CARDS FOR OUR RECORDS

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

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: _____

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:

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

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 Hearing Loss	*If checked, which ear? _____ Gradual Sudden Fluctuating*
_____ 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:_____*

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

_____

_____

_____

_____

_____

_____

Signature of Patient or Guarantor: _____ Date: _____