Appalachian Hearing & Balance

CHILD CASE HISTORY

Child's Name_____ **DOB**_____ **Age**_____
FIRST M.I. LAST

Address_____ **SSN**_____
CITY STATE ZIP

Phone #: Home:_____ **Cell:** _____ **Work:** _____

Father's Name_____ **Mother's Name**_____

Who referred your child to this clinic? _____

Parent's chief concern? _____**When was the problem noticed?**_____

Is there a family history of:
Hearing Loss_____ **Speech/language delays**_____ **Ear Infections**_____ **Developmental delays**____

Does your child have:
Hearing Loss_____ **Developmental delays**_____ **Ear Infection(s)** _____

If you checked ear infection(s), please describe <u>when they started</u>, <u>how many</u>, <u>how treated</u>, and <u>date of last infection</u> _____

Were there problems during pregnancy? If yes, please explain_____
_____

Were there problems during delivery? If yes please explain_____
_____

Was your child ever admitted to the intensive care unit? If yes please explain_____
_____

Has your child been diagnosed with an illness/delay/impairment/syndrome/etc.? If yes, please explain
_____

Did your child have a hearing test before being discharged from the hospital? If yes, did he/she pass or fail?
_____

At what age did your child: Speak_____ **Walk**_____ **Crawl**_____ **Sit up**_____

How many words can your child say? (average) _____ **Can s/he put words together?**_____

Is your child in or have they been in speech/language therapy? _____ **How long?** _____

How would you assess your child's motor skills? (walking, jumping, ect.)_____

2016

How would you assess your child's school progress? _____

Any concerns from his/her teacher? _____

Has you child been given any medication that you were told could affect his/her hearing or balance?
_____

Please list the medications your child is currently taking _____
_____

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. PLEASE INITIAL: _____

PLEASE BRING YOUR CHILD'S INSURANCE CARD(S) WITH YOU TO BE COPIED FOR HIS/HER FILE.

I hereby authorize Appalachian Hearing & Balance to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

By signing below, you agree to give consent to, and agree to hold harmless (agree not to file suit or claim for damages), the audiologist, to perform cerumen removal and/or earmold impressions, if needed. These procedures add an element of risk to the eardrum and ear canal. Some of the risks included, but are not limited to, eardrum perforations (rupture), laceration (cut), and bruising of the canal wall. Placing a hearing aid in the ear canal, also runs the risk listed above

_____	_____	_____
Signature of person completing form	**Relationship to child**	**Date**

2016

Medical Release of Records

The undersigned herewith authorized Appalachian Hearing & Balance to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency or person for such a release of information for the purpose of consultation, prescription or future treatment and in the interest of the proper management of my disability.

□ By signing below you authorize Appalachian Hearing & Balance to occasionally send you text messages and emails about promotions or information about our practice.

_____

Patient, Parent or Guardian Signature/Date

_____

Witness/Date

2016

Effective Date: January 1, 2003

* **Provider Note: You should consult your state law to avoid potential conflicts or contradictions with the uses and disclosures defined in this document.**

* **I have read the undersigned and understand the Notice of Privacy Practices.**

_____ _____
Patient Signature Date
or

_____ _____
Patient Representative Date

_____
Relationship to Patient

Can confidential messages (i.e. appointment reminders) be left on your answering machine, voice mail or with a family member?

_____Yes _____No

Please list persons that you authorize release of information to regarding your visits/account including all physicians, schools or agencies you have seen or have referred you

Physician _____ Phone _____

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

2016