Appalachian Hearing & Balance

INFANT 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 when they started, how many, how treated, and date of last infection____

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
____

Please list any 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 CHILD'S INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR 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 also agree to give consent to, and agree to hold harmless (agree not to file suite 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 risk 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**

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