



Pediatric Intake Form

Appointment Date: ____/____/____

Child's Name: _____

Date of Birth: ____/____/____

Address: _____ Apt: _____

Home Phone: (____) ____ - ____

City: _____ State: ____ Zip Code: _____

Cell Phone: (____) ____ - ____

Gender: Male Female

Which Physician referred you to us? _____

Or by what means did you hear of Audio Help? (Mailer, Ad, Website) _____

Your Child's Hearing History

1. Do you now, or have you ever had, any concerns about your child's hearing? _____
2. Does your child have a permanent hearing loss that you are aware of? _____
If yes, please describe the hearing loss (for example: loss in one ear only, can't hear high pitch sounds): _____
3. Has anyone ever expressed concern about your child's hearing? _____
4. Does your child respond to sound consistently? _____
5. Do you feel you need to repeat things for your child in order to be understood? _____
6. Does your child say "what?" or "huh?" frequently? _____
7. Do you need to raise your voice in order for your child to respond? _____
8. Does your child sit close to the television, or does he/she turn up the volume? _____
9. Does your child appear to have difficulty understanding speech in background noise? _____
10. Has your child had a formal hearing test by an audiologist? (Not just a screening at the doctor's office or in school)? _____
11. Does your child continue to have ear infections? _____
If yes, approximately how many does he/she experience each year? _____
12. Has your child had an ear infection in the last 6 months? _____
13. Has your child ever been treated with antibiotics for an ear infection? _____
If yes, has your child been treated with more than one antibiotic? _____
14. Has your doctor ever observed fluid behind your child's eardrums? _____
15. Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)? _____
16. Has your child ever received pressure equalizing (ventilating) tubes for chronic ear infections?

How many sets of tubes? _____ At what age(s)? _____
17. Any recent hospitalizations / surgeries? _____
18. Any history of ear disease? _____
19. Family history of hearing loss? _____

Additional Comments/Observations: _____



Insurance Information

1st Insurance Company: _____
2nd Insurance Company: _____
Primary Insured Name: _____
Relationship: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Primary Physician: _____
Specialty: _____

Send a report to Physician? Yes No

COPAY DUE AT TIME OF SERVICE

Insurance ID: _____
Insurance ID: _____
Date of Birth: ____/____/____
Email: _____
Home Phone: (____) ____ - ____
Employer: _____

Phone Number: (____) ____ - ____

Fax Number: (____) ____ - ____

Send a report to Guardian? Yes No

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-ups among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

___ I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

___ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby authorize payment of any benefits by my insurance company (otherwise payable to me) directly to Audio Help Associates. I understand I am fully responsible for any charges not covered by my insurance company.

Signature: _____ Date: _____