Link Audiology

## Birth to 6 months
## PERSONAL INFORMATION:

Name: _____ Date: _____

Parent's name (if patient is under 18 yrs): _____

Male Female (please circle) Date of Birth: _____ SS#: _____

Address: _____

City: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Carrier: _____

Email Address: _____ May we send you email? No Yes

Employment Status: (please circle): Employed Retired Unemployed Student

Place of Employment: _____ Occupation: _____

Emergency contact: _____ Phone # _____

Relationship: _____

## CONTACT METHODS (FOR PRIVACY):

Keeping in mind that cell phones, txt messages, and email are not a secure and private line, please indicate one or more methods by which you prefer to be contacted by our office:

____home phone ____cell phone ____txt message ____work phone ____e-mail ____mail to home

Other: _____

If you want to have your billing statements and/or other correspondence from our office sent to an address other than your home, please list it here: _____

_____

____Check if you DO NOT want to receive reminder calls about upcoming appointments.

____Check if you DO NOT want messages left on your answering machine or voice mail.

## REFERAL INFORMATION:

Who referred you or how did you find out about us? _____

Primary Care Physician: _____ Phone: _____

## NEXT PAGE

## INSURANCE INFORMATION:

(Please fill out the information below and provide the front desk with you insurance cards for copying to assist us in billing your insurance company for you.)

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Subscriber's Place of Employment: _____ Subscriber's Place of Employment: _____

Subscriber's relationship to patient: _____ Subscriber's relationship to patient: _____

## CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT:

**Assignment, Release & Financial Agreement**: I authorize treatment of person named above by Link Audiology, LLC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Link Audiology, LLC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims, and audit of payments.

Patient or Guardian Signature: _____ Date: _____

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Link Audiology, LLC. (Copies are available at the front desk.)

Patient or Guardian Signature: _____ Date: _____

Print name and relationship if signed on behalf of patient: _____

## STAFF NOTES:

_____

_____

_____

Link Audiology

## MEDICAL HISTORY:

Please check the boxes if your child has or has had any of the following medical conditions:

☐ Cancer ☐ Mumps ☐ Diabetes ☐ Ear infection ☐ Vision difficulty

☐ Ear Pain ☐ Head trauma ☐ Seizures ☐ Head, neck, or ear surgery

☐ Meningitis ☐ Neurofibromatosis ☐ Cytomegalovirus (CMV)

☐ Drainage from the ear within the past 90 days ☐ Fever/cold requiring hospitalization

☐ Sudden or rapidly progressing hearing loss within the past 90 days

☐ Cardiovascular disease: _____

☐ Autoimmune disease: _____

☐ Allergies: _____ ☐ Developmental delay: _____

☐ Second-hand tobacco exposure ☐ Other, not listed: _____

## PRENATAL AND BIRTH HISTORY

Please list any illnesses or complications that occurred during the pregnancy:_____

_____

How long was the pregnancy? _____ Length of hospitalization: _____

Newborn hearing screening results: PASS / PASS AT RETEST / REFER

After birth, did your child have:

☐ Breathing difficulties ☐ Admission to NICU ☐ Kidney problems ☐ Skin tags or pits

☐ Jaundice requiring transfusion or phototherapy ☐ Head/neck/ear abnormalities

☐ Diagnosis/suspicion of syndrome or other disorder ☐ Genetic anomaly: _____

## FAMILY HISTORY

Is there a family history of hearing loss before age 40? YES / NO

If yes, please elaborate: _____

_____

## DEVELOPMENTAL HISTORY

Does your child startle to loud sounds? YES / NO

Are you concerned about your child's ability to hear? YES / NO

If yes, please elaborate: _____

## MEDICATION LIST

Please list any medications that you are taking, including vitamin supplements.

| Medication | Route (Oral, IV, etc.) | Dose | Frequency |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## OTHER SERVICES

Is the child currently receiving other services, such as…

☐ Speech-language therapy ☐ OT/PT Therapy ☐ Psychological/psychiatric

☐ Neurological treatment ☐ Otolaryngology treatment ☐ Other: _____

☐ Hearing aids or other amplification: _____

## OFFICE USE ONLY

NOTES: _____

_____

_____

_____

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_____

_____