# Pediatric Case History Form

Welcome to Audiology Services of West Virginia! We strive to do our best to help you reconnect to your world and communicate with your friends and loved ones through hearing. Please fill out this form completely. If you have questions, please ask our Patient Care Coordinator!

## PATIENT INFORMATION

Today's Date: _____

I prefer to be called: _____

First Name: _____ Last: _____ MI: ___

Guardian's Name(s):_____

DOB: ____ /____ /____ ☐ Male ☐ Female

SSN: _____-____-_____

Home Address: _____

_____

CITY STATE ZIP

Preferred Phone #: _____ (Home/Cell/Work)

Other Phone #: _____ (Home/Cell/Work)

Email Address: _____

Preferred Contact Method (circle one): Email Cell# Wk# Hm#

Best times to reach you? _____

School: _____

Other family members seen by us?_____

Child's Interests: _____

_____

What are your goals for today's appointment?

_____

_____

_____

What questions do you have for your provider today?

_____

_____

_____

Does your child have a Primary Care Physician? ☐YES ☐NO

Physician's Name: _____

Phone #: _(____)_____ Last Visit: ___ / __ / _____

Has your child's hearing been tested? ☐Yes ☐No

If yes, date & location of last exam: _____

Has your child been diagnosed w/ hearing loss? ☐Yes ☐No

## REFERRAL INFORMATION

**We like to know how our patients found us! Please mark all that apply**

| | | |
|---|---|---|
| ☐ Physician | ☐ Friend / Co-worker | ☐ Facebook Page |
| ☐ Audiologist | ☐ Health Plan / HMO | ☐ Twitter |
| ☐ Internet | ☐ Family Member | ☐ TV Commercial |
| ☐ Voc. Rehab. | ☐ Hospital Referral | |
| ☐ Yellow Pages | ☐ Our Website | |

☐ Other: _____

☐ Name of Person Who Referred You: _____

## PARENT INFORMATION

His/Her Name: _____

Relationship to Patient: _____

DOB: ____/____/_____ Best Phone #: _____

Billing Address: _____

Relation: _____ Phone: _____

## INSURANCE INFORMATION

Person Responsible for Account: _____

**Name of Insured**: _____

**DOB of Policy Holder**: ___/___/___ Relation: _____

**Please provide our Patient Care Coordinator with a copy of your most recent insurance cards. If you are NOT the primary insured, please be sure to include the primary insured's name and information in the provided area above for billing purposes.** ***Services may be denied or extra charges may apply if insurance information is not presented.***

## EMERGENCY CONTACT

Name: _____

Relation: _____

Preferred Phone #: _(___)_____

Other Phone #: _(___)_____

## MEDICAL INFORMATION

Do you have concerns for your child's hearing? ☐YES ☐NO
If Yes please explain: _____
Age of mother at child's birth: _____
Child's birth weight: _____ Length of Pregnancy: _____

**Mother's Prenatal History: (please check all that apply)**

☐ RH Incompatibility
☐ CMV
☐ Rubella/Measles
☐ Medication Taken
☐ Maternal Illness
☐ Toxemia
☐ Substance Abuse
☐ Infections
☐ Lack of Oxygen
☐ Communicable Disease
☐ Venereal Disease/STD
☐ Other: _____

**Please check any conditions that occurred during childbirth:**

☐ Caesarean
☐ Lack of Oxygen
☐ Medication given to Mother
☐ Medication given to Child
☐ Congenital Abnormality
☐ NICU Stay Required
☐ Oxygen Administered
☐ Jaundice

Please Explain: _____

**Child's Hearing History: (please check all that apply)**

☐ Medical/Surgical treatment for ears?
☐ PE Tubes If Yes, what age: ____
☐ Family History of Hearing Loss
☐ Child complaining of pain or fullness in ears?
☐ Exposure to loud noises? (i.e. gunfire, explosions)
☐ History of Ear Infections If Yes, date of last episode: _____
☐ Fall/lose balance easily
☐ Has the child reported hearing noises in ear(s)?

Please Explain any marked: _____

**Child's Health History:**
**(please check all the apply & list date of occurrence)**

☐ Measles _____
☐ Scarlet Fever_____
☐ Sinusitis _____
☐ Seizures _____
☐ Head Injury _____
☐ Tonsillitis _____
☐ Encephalitis_____
☐ Other _____
☐ Chicken Pox _____
☐ Frequent Colds _____
☐ Draining Ears _____
☐ Meningitis _____
☐ High Fever _____
☐ Mumps _____
☐ Flu _____

Please List current Medications your child is prescribed/taking:

_____

_____

Did your child meet gross motor milestones (ex: walking?)

☐YES ☐NO If No, Please Explain: _____

Is your child enrolled in speech, occupational, or physical therapy?

☐YES ☐NO If Yes Please Explain: _____

Is your child meeting speech/language milestones?

☐YES ☐NO If No, Please Explain: _____

Age at child's first word: _____ Number of words used: _____

Does your child follow multi-step directions? ☐YES ☐NO

Other Concerns: _____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidences and it is my responsibility to inform this office of any changes to my medical or personal status as it pertains to these records. I authorize this practice to perform any necessary Audiological services that I may need during diagnosis and treatment with my informed consent and, when appropriate, to bill my insurance company for services. I accept full responsibility for charges incurred as a result of Audiological services or remaining balances following insurance remittance and agree to pay balances and/or any legal fees or court costs associated with collecting any balance due.

_____ _____
Signature Date

***Payment for services is due in full at the time of the service unless prior arrangements have been approved.***

### Acknowledgement of Receipt of Notice of Privacy Practices

This company's Notice of Privacy Practices may be found online at www.hearwv.com or in hard copy.

I attest that I have been given the opportunity to receive a copy of this office's Privacy Practices or have been directed to a copy of these practices that may be accessed either in hardcopy or electronic copy. Please notify the office's Patient Care Coordinator if you would like a printed copy of Privacy Practices.

_____ _____
Signature Date

**Thank you for completely filling out this form for us today. It will allow us to more effectively help you to make decisions about your hearing healthcare. If you have any questions, at any time, please feel free to ask! We are happy to help.**

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