HearingDoctors
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PEDIATRIC HEARING HEALTH REPORT

Confidential Information for Patients Less Than 18 Years Old

Date:_____ Pediatrician:_____ Referred by:_____

Reason for Referral:_____

Patient's Name:_____ Gender: ○Male ○Female DOB:_____ Age:____

Address:_____ City/State/Zip:_____

Parent 1 Name:_____ Home Phone:_____ Cell:_____ Email:_____

Parent 2 Name:_____ Home Phone:_____ Cell:_____ Email:_____

Primary Insurance:_____ Insured Name:_____ Insured DOB:_____

Primary Insurance ID #:_____ Primary Insurance Group #:_____

Secondary Insurance:_____ Insured Name:_____ Insured DOB:_____

Secondary Insurance ID #:_____ Secondary Insurance Group #:_____

How did you hear about us? ○Mail ○Phone ○Newspaper ○Yellow Pages ○Television ○Web ○Physician ○Referral

Hearing & Health History

Was pregnancy/delivery of patient normal? (Check one) ○Yes ○No
*If "No", please explain:*_____

Was the patient in the NICU? ○Yes ○No
*If "Yes", for how long?:*_____

Is/was there a deformity of the ear? ○Yes ○No
Cleft Lip/Palate? ○Yes ○No

Did patient pass his/her newborn hearing screening? ○Yes ○No
For both ears? ○Yes ○No

Has the patient experienced chronic ear infections? ○Yes ○No
*If "Yes", when was the last one?:*_____

Has the patient ever had tubes placed in the ears? ○Yes ○No
*If "Yes", when/which ear?:*_____

Has the patient had any ear surgeries? ○Yes ○No
*If "Yes", when?:*_____

Is there a family history of hearing loss? ○Yes ○No
*What Relation(s)?:*_____

Has the child previously had his/her hearing tested? ○Yes ○No
*If "Yes", when and where?:*_____

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Amplification & Developmental History

Does the child have a known hearing loss? ○ Yes ○ No

Has the child previously worn/currently wears hearing aids? ○ No ○ Left Only ○ Right Only ○ Both Ears

Are there any concerns regarding the patient's speech/language development? ○ Yes ○ No

If "Yes," is the child receiving therapy/services?: _____

Has there been any history of developmental delays? ○ Yes ○ No

If "Yes," is the child receiving therapy/services?: _____

What concerns you most about the patient's hearing/understanding and communication difficulties?

_____

Please describe any other significant medical history: _____

_____

Release & Authorization

☐ I give Hearing Doctors permission to release the patient's test information and provide status updates to their primary care or referring physician.

Physician Name: _____ Phone Number: _____

☐ I allow Hearing Doctors to release all medical information to the relevant insurance carrier(s). I agree to accept financial responsibility for all charges which are not covered by the insurance carrier(s) for services rendered by Hearing Doctors. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in me being financially responsible for payment in full at the time of visit.

Name of Parent or Guardian Signing Below: _____

Signature of Parent or Guardian:

_____ Date: _____