PAC Audiology

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(425) 455-0526 pacaudiology.com

Intake form for CHILD

OK to leave a voicemail? Yes No
OK to send a text message? Yes No

Mr. Ms.

Patient Name _____Male ____Female____
First Last MI

Address _____City_____State____Zip_____

Birth Date _____ Age _____ Email Address_____

Home/Cell Phone_____ School _____ Grade_____

Primary Care Physician _____ Phone #_____

Referring Doctor _____ Phone #_____

How did you hear about us? _____

Emergency Contact Name_____ Relationship to Patient_____
Emergency Phone Number/Email Address_____

I authorize PAC Audiology to call and/or leave messages regarding appointments, patient care and billing at the following individual(s):
NAME _____ RELATIONSHIP _____ PHONE _____

Please complete Insurance Primary Subscriber's Information, if different from patient
Primary subscriber_____ Birth Date_____
Address (if different) _____
Home/Cell Phone _____Work Phone _____

Insurance Release Agreement

We will place a copy of your insurance card and photo ID in chart and bill your insurance for this visit. If correct information is not provided at time of service, you will be responsible for all charges as billed and an **additional $25 Rebilling Fee.** I hereby authorize PAC Audiology to release any information necessary to process insurance claim forms. I also authorize my insurance claim to be paid directly to the clinic.

SIGNATURE _____ **Date** _____

_____ _____
Please PRINT name if signing as parent or guardian **Relationship to patient**

I hereby designate the following individual(s) to receive communications from PAC Audiology that may include health information about me.
Referral MD/PCP: _____
School/Name of Teacher/Counselor: _____

Confidentiality and Privacy Policy

The purpose of this policy is to protect a patient's right to confidentiality and privacy. Patient information will be regarded as confidential and will be available only to authorized users for approved purposes. Every Provider, Staff, Contractor or Student will use only the minimum amount of confidential patient information to accomplish their assigned duties. Access to confidential information is only permitted for direct patient care, billing, or administrative operations.

Discussion or consultation involving a patient's care should be conducted in private. Individuals not directly involved in the patient's care should not be present without the patient's permission.

1. Discuss patient information with authorized personnel only and only in a private location where unauthorized persons cannot overhear.
2. Minimize how audible we are when discussing patient information on the phone while keeping in mind that sometimes we must speak loudly for our patients who are hard of hearing.
3. Keep medical records secure and unavailable to persons not involved with the patient's care.
4. Follow specified procedures for use of electronic information systems, including use of passwords, logging off when finished, and protection of displayed or printed information from unauthorized users.
5. Omit the patient's name and other unique identification when using case reports for educational purposes.
6. Verify with the patient what information may be given to the patient's family and friends with the patient's knowledge and permission.
7. Release patient medical records to external sources only upon receipt of written authorization from the patient.
8. Obtain permission from the patient before we use either their email or home address to send them marketing material, patient newsletters, or any other general information regarding PAC Audiology.

PATIENT AGREEMENT

Please initial the following:

_____ By my signature below, I acknowledge that a copy of the PAC Audiology's Confidentiality and Privacy Policy has been made available to me.

_____ I have provided PAC Audiology with my current insurance information. I understand that ultimately the charges for their services will be my responsibility. I authorize any holder of medical or other information about me to release and information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ I authorize PAC Audiology to contact me regarding evaluations; recall notices or any general information about PAC Audiology such as any changes in our address, phone number, hours of operation etc…

Signature: _____ Date:_____

_____ _____

Please PRINT name if signing as parent or guardian Relations to patient

Please describe your concerns and any diagnoses and treatments your child has had for the issues:

_____

_____

Prenatal/Birth history:

Length of pregnancy?_____ Birth weight?_____APGAR Score_____
List medication/drugs used during pregnancy including alcohol:
_____
Unusual Pregnancy: _____ Yes ☐ No ☐
Illness while pregnant (Herpes,Syphilis,Rubella,CMV) Yes ☐ No ☐
Complicated delivery? Yes ☐ No ☐

After birth did this child have:

Newborn hearing screen? Pass☐ Fail ☐ No ☐
Breathing difficulties (ventilation)? Yes ☐ No ☐
Admission to Intensive Care Unit (NICU)? Yes ☐ ___ days No ☐
Head, Neck, or ear abnormalities? Yes ☐ No ☐
Skin tags or pits near the ears? Yes ☐ No ☐
Jaundice (high bilirubin)? Yes ☐ No ☐ How long? ____
Head trauma/defects? Yes ☐ No ☐
Surgery? Yes ☐ No ☐ _____
Diagnosis of neurologic condition? Yes ☐ No ☐
Vision problems? Yes ☐ No ☐
Kidney problems? Yes ☐ No ☐
Overnight hospital stays? Yes ☐ No ☐
Emergency room visits? Yes ☐ No ☐

Others? _____

Hearing and Middle Ear History:

Pervious hearing test? Yes ☐ No ☐ When? _____
Loud noise exposure? Yes ☐ No ☐
Balance or coordination problems? Yes ☐ No ☐
Number of ear infections? _____ Age resolved? _____
P.E Tubes placed? Yes ☐ No ☐ If yes, who placed tubes, and at what age? _____
History of ear pain? Yes ☐ No ☐
History of ear discharge? Yes ☐ No ☐
Is there a family history of hearing loss? Yes ☐ No ☐ If yes, what is the age of onset? _____

Communication and Development:

Difficulties with pronunciation? Yes ☐ No ☐
If yes, describe _____
Language development concerns? Yes ☐ No ☐
If yes, describe _____
Difficulties listening/understanding? Yes ☐ No ☐
If yes, describe _____
Attention problems at school? Yes ☐ No ☐
If yes, describe _____
Other developmental delays? Yes ☐ No ☐
If yes, describe _____
Child frequently ask for things to be repeated? Yes ☐ No ☐
Child babble around 5-6 months of age? Yes ☐ No ☐
Child look for sounds behind him/her at 13 months of age? Yes ☐ No ☐
Child begin to imitate sounds? Yes ☐ No ☐
Child responds to sounds and voices? Yes ☐ No ☐
Child startles at loud noise? Yes ☐ No ☐
Child looks for the source of sounds? Yes ☐ No ☐

Please list medication your child is taking or provide the medication list:

_____ _____ _____

_____ _____ _____

Please circle any of the following physical conditions your child has had….

ear surgery	ear malformations	allergies
cleft palate	kidney trouble	diabetes Type I/Type II
fragile bones	fainting spells	high blood pressure
head injury	mumps	scarlet fever
measles	meningitis	cancer
chronic conditions	ER Visits	overnight Hospitalization
meniere's disease	otosclerosis	cholesteatoma
sudden hearing loss	attention disorders	anxiety disorders
depression disorders	dexterity disorders	

others_____