BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

PATIENT INFORMATION FORM – CHILD CASE HISTORY

Child's Name: _____ Appointment Date:_____

Date of Birth:_____ Age: _____

Gender: Male Female

Primary Language:_____

Social Security Number: _____

Parent/Guardian Name: _____

Relationship to child:

Biological Adoptive Foster Grandparent Step Other: _____

Address:_____

City:_____State:_____ Zip:_____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

School: _____

Are you in contact with the South Dakota School for the Deaf? Circle one: Yes or No

If yes, list consultant's name here: _____

Family Physician/Clinic Name: _____

Date and location of the child's last hearing test? _____

Emergency Contact & Phone Number: _____

Who refered you to our office?

Physician Internet Health Plan Audiologist VA Service Mailer Friend/Family Member
Ad/Article Walk In/Drive by Health Fair Website Radio Other: _____

Referral Name/ Anyone else encourage you to come today (If applicable): _____

HEARING HEALTH QUESTIONNAIRE:

What is your chief complaint/reason for the visit?_____

Do you feel your child may having hearing loss? Yes or No

If so, circle one: Left Ear Right Ear Both Ears

Do you know the cause of the hearing loss?_____

When did you first notice the hearing loss?_____

Did your child have a traumatic birth? Yes or No

If yes, describe: _____

Length of pregnancy: _____ Birth weight: _____

Did the child spend any time in the NICU? Yes or No

If yes, for how long? _____

What was your child's APGAR score? Don't know Less than 7 7 or more

What were the results of your child's hearing screening at birth? Circle one:

Passed both ears Did not pass either ear Did not pass left ear only Did not pass right ear only

Did any of the following occur during pregnancy? (Circle all that apply)

Alcohol abuse Substance Abuse Smoking German Measles/Rubella Infections

Venereal disease Maternal illness Cytomegalovirus (CMV)

Has your child ever taken any of the following medications? (Circle all that apply)

Vancomycin Chemotherapy Gentamycin Streptomycin

Has your child ever had a fever greater than 104°? Yes or No

If yes, how old was your child? _____ How long did it last? _____

Has your child had any of the following? (Circle all that apply)

Ear infections/fluid Draining ear(s) Allergies Tonsillitis Frequent colds Flu High fevers

Seizures Breathing difficulties Blood transfusion Chicken Pox Measles Mumps

Rubella Cytomegalovirus (CMV) Encephalitis Meningitis Scarlet fever

Pulmonary hypertension Head trauma (hospitalization required) CHARGE syndrome

Down syndrome Cleft lip and/or palate Small/absent ear(s) Skin tags or pits around the ear(s)

Family history of hearing loss If other, describe: _____

Has your child had medical or surgical treatment of their ears (for example, PE tubes)? Yes or No

Does your child ever complain of pain or fullness in their ears? Yes Sometimes No

Has your child ever been exposed to loud noises or an explosion? Yes or No

Has your child ever described noises in their ears? Yes Sometimes No

If yes, circle one: Left Ear Right Ear Both Ears

Does your child fall or lose balance easily? Yes Sometimes No

Has your child been diagnosed with any specific condition? Yes or No

If yes, what is your child's condition? _____

If you find out your child has hearing loss are you ready for help? Circle one: Yes No Maybe

If no or maybe please explain: _____

Does your child currently wear hearing aids? YES or NO

Hearing Aid Brand: _____ Where/when did you get the hearing aids?_____

If your child has a cell phone, laptop, or tablet what kind is it? Please list any details of the device (example- iPhone/Android, how many years have you had this device, and if it is bluetooth compatible?)

_____

Does your child have difficulty communicating at home? Yes Sometimes No

Does your child have learning difficulties or educational concerns? Yes Sometimes No

Does your child struggle in social situations? Yes Sometimes No

Does your chilld have speech or language difficulties? Yes Sometimes No

Does your child prefer the TV at a louder than normal volume? Yes Sometimes No

Does your child feel embarresed or frustrated in noisy or group settings? Yes Sometimes No

Does your child have sensativity to sound? Yes Sometimes No

<u>If your child is an infant, answer the following:</u>

Does your child respond consistently to sounds? Yes Sometimes No

Does your child turn to find a sound source? Yes Sometimes No

Does your child enjoy listening to music? Yes Sometimes No

Does your child respond to their name? Yes Sometimes No

Does your child startle to loud sounds? Yes Sometimes No

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HIPAA/Communication/Consent to Treatment

Our Notice of Privacy Practices provides information about how we may use and disclose protected information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting Baker Audiology.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy dated August 13th, 2018.

Communication with Family and Friends

Baker Audiology may share medical and/or billing information with the following individuals who are involved with the patient's care:

Release to:_____ Relationship:_____

Release to:_____ Relationship:_____

Wireless Communications

I hereby agree that by providing my wireless/cell phone number, I am, hereby granting my consent to receive communication on my wireless/cell phone number for business related to my healthcare services or payment thereof. Methods of contact may include messages on your phone directly from our office on your voicemail and text messages.

◯ Decline

Authorization for Treatment

I consent to treatment for myself or my family from Baker Audiology & Hearing Aids:

Signature of patient: _____

Printed name of patient: _____

Signature of representative if other than patient: _____

Printed name of representative if other than patient:_____

Relationship to patient:_____

Time: _____

Date:_____

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Policy, billing and release of medical records Authorization, Notice of privacy practices acknowledgment of receipt:

*We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.
Please Initial _____

*I request that payment of authorized benefits be made on my behalf to Baker Audiology & Hearing Aids for services furnished to me by the provider. I authorize any holder of medical information about me to release to Baker Audiology & Hearing Aids. Any information needed to determine these benefits or the benefits payable for related services.
Please initial:_____

*I hereby authorize you to release, to my attorney(s) and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.
Please initial:_____

*I acknowledge that I have been given the opportunity to read the notice of privacy practices for the office of Baker Audiology & Hearing Aids. A copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request. **Please initial:_____**

*In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.
Please initial: _____

*I acknowledge that my audiologist may use a secure, HIPAA-compliant artificial intelligence (AI) tool to assist in generating chart notes based on our visit. This tool is used soley to improve the accuracy and efficiency of documentation. My personal health information will be handled with strict confidentiality and in accordance with all applicable privacy laws.
Please initial: _____

*In further efforts to protect your health information and confidentiality of your healthcare, we ask that you designate below to whom the staff may discuss your healthcare and scheduling needs as well in the event of any issues that may arise.

Please list any Name, relationship, and phone numbers of the designated people:

_____

Signature of Patient: _____

Signature of Parent or Guardian: _____

**** Please provide our front desk staff with your insurance card****