Hearing Associates of Dothan, LLC

Pediatric Patient Registration Form

☐ New patient registration
☐ Update of current patient demographic information

Demographic Information

Patient Name: _____ Today's Date: _____

Street Address, City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone #: _____

E-mail Address: _____ Spoken Language: English Spanish Other

How would you like to be contacted regarding appointments? ☐ Call ☐ Text ☐ E-mail

Date of Birth: _____ Social Security Number: _____ Gender: Male or Female

Marital Status: Single Married Divorced Widowed **Name of Spouse, if applicable: _____**

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

Primary Insurance: _____Secondary Insurance: _____

Responsible Party/Name of Insured (if different than above): _____

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address, if different: _____

Referring Physician Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone#: _____

We will send a copy of your test results and/or report to your referring or ordering physician. If you would like for any additional physicians and/or other entities to receive a copy of your tests and/or report, please notify our receptionist and fill out a records release.

How did you hear about us? (*Please check all that apply*):

_____ Phone book	_____ Sign	_____ Internet	_____ Health Fair
_____ Family Member	_____ Doctor	_____ Direct Mail Piece	_____ Open House
_____ Website	_____ Friend	_____ Newspaper	_____ Facebook
_____ Other: _____			

We will make a copy of the front and back of your insurance cards for our records.

Allergies (food, medications, plastics, etc.): _____

Current Medications (drug name, dosage, frequency and method):

_____

_____

See other side

Has your child experienced any of the following major medical conditions:

_____ AIDS/HIV	_____ Cerebral Palsy	_____ Heart Problems	_____ Schizophrenia
_____ Autism	_____ Chicken Pox	_____ Kidney Disease	_____ Seizure Disorder
_____ Aspergers/PDD	_____ Diabetes	_____ Measles	_____ Speech/Lang Delay
_____ ADD/ADHD	_____ Encephalitis	_____ Meningitis	_____ Thyroid Disorder
_____ Bipolar Disorder	_____ Genetic Disorders	_____ Multiple Sclerosis	_____ Visual Deficit
_____ Cancer	_____ Head Injury	_____ Obsessive Compulsive	_____ Other: _____

Was your child born full term? Yes or No **If No, when? _____**

What was your child's birth weight? _____

Did you experience any of the following complications during pregnancy:

_____ Illness, fever, pneumonia, or flu like symptoms	_____ High Blood Pressure
_____ Exposure to alcohol	_____ Stress/Anxiety
_____ Exposure to drugs (prescription, illegal, other)	_____ Pre-eclampsia
_____ Exposure to smoking	

Did your child experience or require any of the following after delivery:

_____ Need for Oxygen	If checked, please state how many days/weeks? _____
_____ Need for IV antibiotics	If checked, please list the name of antibiotics _____
	If checked, please state how many days/weeks? _____
_____ Jaundice	If checked, did your child receive phototherapy? Yes or No
	If checked, did your child receive any blood transfusions? Yes or No

Please check <u>all</u> medical conditions that apply:

_____ Vertigo, Dizziness, or Unsteadiness	*If checked, is it accompanied by: Vomiting Nausea Ear Noises*
_____ Ear Deformity	*If checked, Right ear Left Ear Both ears*
_____ Ear Drainage (past 90 days)	*If checked, Right ear Left Ear Both ears*
_____ Ear Pain or Discomfort	*If checked, Right ear Left Ear Both ears*
_____ Family History of Hearing Loss	*If checked, who?* _____
_____ History of Ear Infections	*If checked, Right ear Left Ear Both ears If so, when?* _____
_____ History of Ear Wax Buildup	
_____ History of Noise Exposure	*If checked, please describe?* _____
_____ Hypersensitivity to Sounds	*If checked, please describe?* _____
_____ Previous Ear Surgery	*If checked, Right ear Left Ear Both ears If so, when?* _____
_____ Tinnitus/Ringing/Noises in ears	*If checked, Right ear Left Ear Both ears Frequency?* _____
_____ Other:	*Please describe:* _____

Signature of Patient or Guarantor: _____ Date: _____