Peninsula Hearing Services, Inc.

105 Shady Lane, Soldotna, AK 99669 (907) 262-3224

PEDIATRIC REGISTRATION

Child's Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

May we send you notification by mail? Yes No SSN: _____ (optional)

Primary Phone: _____ Type: Home Work Cell Contact: _____

Secondary Phone: _____ Type: Home Work Cell Contact: _____

Do you authorize us to leave a detailed message on your primary phone? Yes No Secondary Phone? Yes No

What is the reason for today's appointment? _____

Patient's Parent or Guardian Information

*Please fill in information for all parties responsible for patient

Primary Contact: _____ Date of Birth: _____ Relationship: _____

Employer: _____ E-mail: _____

Secondary Contact: _____ Date of Birth: _____ Relationship: _____

Employer: _____ E-mail: _____

Patient's Physician Information

Primary Physician: _____ Clinic: _____

Referring Physician (if different): _____ Clinic: _____

Reason for the referral: _____

** All contact information, including e-mail address will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Parent/Guardian initials: _____

By signing below, I hereby authorize Peninsula Hearing Services, Inc. to use and/or disclose individually identifiable health information which is called "protected health information" or PHI under the Health Insurance Portability and Accountability Act of 1996 or "HIPPA", and/or medical, audiologic or hearing aid records relating to me. This medical information may be used by the person I authorize to receive this information for billing or claims payment. I understand that this authorization expires five years from the date on the authorization listed below. I understand that I may revoke this authorization at any time by notifying Peninsula Hearing Services, Inc. in writing.

I wish to receive a copy of the Notice of Privacy Practices Yes No

Print name of patient: _____

Patient Signature: _____ Date: _____

For Patient's Parent or Guardian, if applicable:

Print name of Parent or Guardian: _____ Relationship: _____

Parent or Guardian Signature: _____ Date: _____

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PEDIATRIC CASE HISTORY

Patient Name: _____ **Date of Birth:** _____ **Date of Service:** _____

CHILD'S HEARING HISTORY

(please circle appropriate answer and provide further information where necessary.)

Did your child pass his/her newborn hearing screening? Yes No

If no, which ear or both? _____

Any previous hearing tests? Yes No

If yes, where and what were the results? _____

MOTHER'S PREGNANCY HISTORY FOR THIS CHILD

Length of pregnancy: _____ Drug/alcohol use (specify): _____

Infections (Rubella, CMV, Herpes, Toxoplasmosis)? _____

Medications (specify): _____ Any complications? _____

CHILD'S BIRTH HISTORY

Normal with no complications? Yes No If no, specify complications: _____

Low birthweight (below 3.3 pounds/1500 grams)? Yes No

Breathing problems? Yes No (specify) _____

Jaundice requiring blood transfusion? Yes No _____

Birth defects? Yes No (specify) _____

CHILD'S MEDICAL HISTORY

Family history of hearing loss? Yes No If yes, who? _____

Has your child had any ear infections? Yes No If yes, most recent: _____

Has your child had any ear surgery (PE tubes, etc.)? Yes No (specify) _____

Medical problems? Yes No (specify) _____

Balance problems? Yes No (specify) _____

Please describe your child's responsiveness to sound: _____

Any speech or language concerns? Yes No (specify) _____

Any educational concerns or problems? Yes No (specify) _____

Name of school: _____

Other significant information: _____

_____