Pediatric Intake Form

Date: ______________________ DOB (MM/DD/YYYY): ______________________

First Name: ______________________ Last name: ______________________

Mailing Address: ____

City: ______________ State: ______________ Zip: ______________

Preferred Telephone #: ______________________ ☐ Cell ☐ Home ☐ Work

Alternative Telephone #: ______________________ ☐ Cell ☐ Home ☐ Work

Email Address: ____

Local/Referring Physician): ____

Hearing Aid Insurance/Health Plan: ______________________ Policy #: ______________

How did you hear about us?____

Parent/Guardian Name: ____

Relationship to Patient: ____

Child Case History

Patient's name: ______________________ DOB/Age: ______________________

How were you referred to our practice? ______________________

Who is your family doctor? ______________________ Is it ok to send results? ______________________

If your child has had a hearing test before; where and what were the results? ______________________

____

What concerns do you have about your child's hearing? ______________________

____

Does your child seem to hear better on some days than others? ☐ Yes ☐ No

Does anyone in your family have hearing problems? ☐ Yes ☐ No

List any other family members we have seen at this office: ______________________

Were any of the following present after your child's birth or during the first two months?

- ☐ Prematurity
- ☐ Poor weight gain
- ☐ Was in an incubator
- ☐ Did not pass hearing screen at birth
- ☐ Difficulty breathing
- ☐ Birth weight less than 6 lbs.
- ☐ Appeared Yellow
- ☐ Stayed in hospital after mom went home
- ☐ Infections at birth
- ☐ Physical deformities
- ☐ High fever

Does your child turn toward sound? ☐ Yes ☐ No

Has your child had ear infections? ☐ Yes ☐ No If so, how many? ______________________

Has your child had tubes placed in the ear(s)? ☐ Yes ☐ No

Has your child ever worn hearing aids
or used an FM system in the school? ☐ Yes ☐ No

How is your child performing in school? ______________________

List of Medications

North Houston Hearing Solutions, L.L.C.
Hearing, Balance & Tinnitus Wellness Center

Medication	Condition

Insurance Authorization and Financial Policy

Thank you for choosing North Houston Hearing Solutions as your audiology provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy read, agree to, and sign prior **to testing or fitting of hearing aids.**

Office Services:

Responsibility for payment of your bill is your obligation regardless of insurance **coverage. Insurance is filed as a courtesy to you. Your insurance policy is a contract between you and your** insurance company. We cannot guarantee payment of your claims. We want to make sure, however, that **you understand payment for service is your responsibility. You will be responsible for all non-covered services, amounts exceeding allowed charges, co-pays and deductibles, including Medicare. All co-pays are** due at time of service.

Cases Involving Litigation:

We consider the patient, not the attorney, to be responsible for all fees.

Insurance Authorization:

I hereby authorize North Houston Hearing Solutions, LLC, to furnish information to my insurance carriers and physicians concerning my illness or treatment, or my child's illness or treatment.

I acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If, for any reason, the account should become delinquent, I agree to pay all collection and legal fees. I have read, understood, and agree to the above Financial Policy.

I have read and received a copy of Notice of Privacy Practices.

Signature: ______________________________ Date: ____________________