3113 Lawton Road | Suite 109 | Orlando, FL 32803 | 407-898-2220 | 1-877-769-2047 (fax)

Child Case History

Patient Name: _____ D.O.B.:_____ Age: _____

Address: _____ Apt_____ City: _____ State: _____ Zip: _____

Contact Phone #: _____ Parent's Cell # _____

Parent's Email address: _____

Who referred you to our office: _____

Physician:_____ Physician Phone #: _____

Accompanying Person _____ Relationship: _____

Insurance Company: _____ Phone #: _____

Subscriber of Policy: _____ Policy #: _____Group #_____

1. Reason for visit:_____

2. Has the child had a previous hearing tests (Including Newborn Screening)?

A. When? _____ **B. Where?** _____

C. Results? _____

3. Was patient born full term? Yes or No

If no, what week was patient born?_____ **NICU Admission?** Yes or No

4. Is there a history of cleft lip or palate? Yes or No

5. Is there a family history of hearing impairment? Yes or No

Relationship to patient? _____ **Age of Onset?** _____

6. Is there a history of ear infections? Yes or No **How frequent?** _____ **How treated?**_____

7. Do you experience episodes of dizziness or lightheadedness? Yes or No

8. Is there a history <u>OR</u> hospitalization for any of the following?

a. meningitis	b. encephalitis	c. measles	d. influenza
e. cytomegalovirus	f. diabetes	g. rubella	h. high fevers

9. Other comments that you feel may be helpful for our audiologists?

_____

_____

Date:_____

I, _____ have received a copy or the opportunity to review Hearing Associates of Central Florida, LLC's Notice of Privacy Practices.

_____

Patient/ Guardian Signature

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Authorization to Release Information

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Hearing Associates of Central Florida, LLC** to use and/or disclose certain protected health information (PHI) about me to the following:

Name: Address: Phone #:

_____

_____

_____

_____

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Hearing Associates of Central Florida, LLC
3113 Lawton Road
Orlando, FL 32803
Tel: 407-898-2220
Fax: 877-769-2047

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable