Hearts for Hearing
3525 NW 56th, Suite A-150
Oklahoma City, OK 73112
(405) 548-4300 phone
(405) 548-4350 fax

Appointment Date: ________________Who are you seeing today ____________________________________

Patient Name ____ Gender______ Date of Birth ____________
Language ______________ Social Security _____________________ Primary Care _______________________
County of Residence _____________________ Referred By ____

Address______________________________________City______________________ST____ Zip Code _______

Home Phone ( ) __________________ Work Phone ( ) _________________Cell ( ) _________________

Email ____________________________ Emergency Contact____

Address __________________________________ Phone ( ) _________________Relationship____________

Guarantor (if different from patient)

Name________________________________Relationship________________________Gender______________

Date of Birth __________Social Security_____________________ Home Phone ( ) _____________________

Address____ Cell Phone ( ) ________________________

Employer____ Work Phone ( ) ____________________________

Insurance-Carrier Name __________________________Address______________________________________

Policy _____________________________ Group ____________________ Effective Date ___________________

Subscriber's Name_____________________________ Relationship __________Social Security_______________

Date of Birth _______________ Address (if different) ____

Secondary-Carrier Name_________________________Address____

Policy Number _______________________________ Group ________________ Effective Date______________

Subscriber's Name_____________________________ Relationship ___________Social Security _____________

Date of Birth _____________ Address (if different) ____

I authorized my insurance benefits to be paid directly to Hearts for Hearing. I understand that I am financially responsible for any balance. I authorize Hearts for Hearing or my insurance company to release any information needed to process my claims. I give permission to you and any agent of Hearts for Hearing, to call me on any phone number I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. Signature ______________________________________Date _________

☐check here if you do not wish to receive occasional mailings from Hearts for Hearing (Newsletters, events, etc.)

TODAY'S DATE:____________________________ PERSON COMPLETING FORM:__________________________________

PEDIATRIC CASE HISTORY

CHILD's FULL NAME:____DATE OF BIRTH:_______________________

CHILD'S GENDER: ☐ Male or ☐ Female CHILD's SOCIAL SECURITY NUMBER:___________________________________

PRIMARY LANGUAGE SPOKEN IN THE HOME:____

WHO HAS LEGAL CUSTODY OF THIS CHILD?____

(Name and Relationship to Child)

MEDICAL PROVIDERS

Pediatrician/ Family Physician:____ City:________________________________

Ear, Nose, & Throat Physician:____ City:________________________________

PREGNANCY AND BIRTH HISTORY

Birth Hospital:____ City/State:____

Length of pregnancy:________ Duration of labor:__________________ Birthweight:________________________________

During pregnancy, were there any unusual conditions such as illness, medications, x-rays, measles, blood incompatibility, serious accidents, false labor, threatened miscarriage, substance abuse? _____________________________

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Were there any unusual conditions at or immediately following the birth such as: (circle where appropriate)

Feeding problems	Seizures	Birth Defects	Sluggishness	Silent Baby
Breathing Problems	Cesarean Delivery	Apnea	Induced Labor	Breech Birth
Yellow Color/Jaundice	Respiratory Problems	Blue Color	Oxygen Given	Sucking/Swallowing Difficulties

NICUCMV OTHER____

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MEDICAL HISTORY (circle where appropriate)

Allergies	Mouth Breathing	Measles	Pneumonia
Draining Ear	Mumps	Asthma	P.E. Tubes in Ears
Chicken Pox	Ear Aches	Physical Handicaps	Whooping Cough
Bronchitis	Scarlet Fever		

Describe any major accidents/surgeries:____________________________________

HEARING DEVELOPMENT

	Yes	No	Do Not Know
Did your child pass the Newborn Hearing Screening prior to discharge from the hospital?			
Has your child had any other Hearing Assessments? Name of Facility: City/State: Name of Audiologist: Type of Assessment: Result/Recommendation:			
Does your child appear to respond to your voices?			
Does your child appear to respond to noise?			
Does your child startle to loud noises?			
Does your child turn to locate a sound?			
Does your child respond to spoken directions or questions?			
Does your child's hearing appear to fluctuate?			
Has your child ever worn a hearing aid? What type: How long: Which ear:			

Describe any concerns you have about your child's hearing development.

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SPEECH/LANGUAGE/LEARNING DEVELOPMENT

Please answer these questions according to the current age of your child.

Does/Did your child babble and coo?
Does/Did you child imitate sounds or words?
When did your child say his/her first words?
When did your child begin combining words?
When did your child begin using sentences?
How does your child communicate to request what he/she wants?
How would you describe your child's speech production?
How would you describe your child's ability to follow commands?
How does your child communicate with children of his/her age?

If your child is school aged, describe how your child is functioning in the classroom.
If your child is school aged, describe your child’s ability to read.

Describe any concerns you have about your child’s speech and language.

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EDUCATION

	Yes	No
Is your child receiving Sooner Start Services?		
Does your child receive care outside of the home? What Settings? Home Day Care: Location: Private Day Care: Location: Mother’s Day Out: Location: Preschool : Location:		

Does your child attend school? Grade: Location:		
Does your child currently receive any other special services? Please describe.		

Describe any concerns you have about your child's educational services.

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I give my consent for an audiological/speech-language evaluation and management by Hearts for Hearing. I understand that I will be responsible financially to Hearts for Hearing for services rendered unless previously determined through program director. Additionally, I am aware of this office's Notice of Privacy Practices and fully understand my privacy rights as a patient of Hearts for Hearing.

Patient's Signature____________________________________ Date____________________

Signature of Person Authorized to sign, if other than patient____________________________________

Relationship to patient____________________________________ Date____________________

LISTEN for a Lifetime