Synergy Hearing

Date:_____/____/_____
Birth date:_____/____/____

Home Phone: (_____)_____-_____
Work Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____

Patient:_____
First Name Middle Initial Last Name

Address:_____

City:_____ State_____ Zip_____

Sex: F_____ M_____ Email: _____

Personal Contact in Case of Emergency:_____
Relationship:_____ Phone: (_____)_____-_____

Family Physician:_____ Referring Physician:_____

How were you referred to our office?_____

*If patient is a minor, please complete the following section:
*Responsible Party:_____
*Name and address of Employer:_____
_____

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PLEASE GIVE INSURANCE CARD(S) TO FRONT DESK FOR COPYING

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Assignment of Insurance Benefits

The undersigned authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this consent authorizes Synergy Hearing to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

The undersigned further authorizes the above named insurance company/ies to pay directly to Synergy Hearing, all benefits, if any, otherwise payable for its services as described on any submitted claim or invoice. In the event my insurance does not pay for such services, I understand that I am financially responsible for all charges incurred.

_____ Date:_____/____/_____
Signature of Insured or Authorized Party

Pediatric Audiology History

Name:_____ **Age:**_____ **Date:**_____
Pediatrician:_____
Please send a report to my pediatrician _____ **Yes** _____ **No**

Please check and/or describe all that apply below including the age at which it occurred.

Pre-Natal (Pregnancy)

Length/Term_____
Illness_____
Medications_____
Complications_____

Delivery

Duration/Labor_____
C-Section_____
Position_____

Post-Partum

Birth Weight_____
Jaundice_____
Incubator_____
Lack of Oxygen_____
Craniofacial Anomalies_____

Infancy and Childhood

At what age did your child walk?_____
At what age did your child say his first word?_____

Medical History

High Fevers/Serious Illnesses_____
Seizures/Convulsions_____
Hospitalizations/Surgeries including tonsillectomy, adenoidectomy and/or myringotomy with or without insertion of tympanostomy tubes_____
Past/Present Medications_____
Family history of hearing loss_____

Social History

Does your child interact well with others his/her own age?_____
Behavior Problems?_____
School Grade_____ School Progress_____
School your child is presently attending_____
Name of your child's teacher_____
(Please send a report to my child's school _____Yes _____No)

Do you now, or have you ever had, any concerns about your child's hearing?_____

Does your child have a permanent hearing loss that you are aware of?_____

(for example: loss in one ear only, can't hear high pitch sounds)

Please describe the hearing loss_____

Has any member of your family, or your child's teacher, ever expressed concern about your child's hearing?_____

Specific Questions About Your Child's Hearing History

1. Does your child respond to sound consistently?_____
2. Do you feel you need to repeat things for your child in order to be understood?_____
3. Does your child say "what?" or "huh?" frequently?_____
4. Do you need to raise your voice in order for your child to respond?_____
5. Does your child like to sit close to the television, or does he/she turn up the volume?_____
6. Does your child appear to have difficulty understanding speech in background noise?____
7. Has your child had a formal hearing test by an audiologist?

(not just a screening at the doctor's office or in school)?_____

Specific Questions About Your Child's Ear History

1. Did your child have any ear infections in the first 18 months of life?_____If so, How many?_____
2. At what age did your child's first ear infection occur?_____
3. Does your child continue to have ear infections?_____

   Approximately how many does he/she experience each year?_____

   Has your child had an ear infection in the last 6 months?_____
4. Has your child ever been treated with antibiotics for an ear infection?_____

   Has your child been treated with more than one antibiotic?_____

   How long does it take for an ear infection to clear?_____

   Is your child currently taking antibiotics for prevention of ear infections?_____

   Has your doctor ever observed fluid behind your child's eardrums?_____
5. Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)?_____
6. Has your child ever received pressure equalizing (ventilating) tubes for chronic ear infections?

   How many sets of tubes?_____ At what age(s)?_____
7. Does your child have a frequent runny nose? _____Colds?_____Allergies?_____

Additional Comments/Observations:_____

_____

_____

Synergy Hearing

215-321-2337
Fax: 215-321-2339

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Acknowledgment of Receipt of Notice

I hereby acknowledge that I have read this medical practices' Notice of Privacy Practices.

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

Signed _____ Date _____

Name: Telephone:

If not signed by the patient indicate relationship

_____ Parent or guardian, if patient is a minor
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of patient _____

For office use only:
Signed and received by _____

Acknowledgment refused:
Efforts to obtain:

_____
_____

Reasons for refusal:

_____
_____