

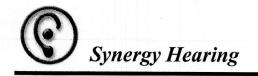
Date://	Home Phone	: (
Birth date://	Work Phone	: (
	Cell Phone:	() -
Patient:First Name		
First Name	Middle Initial	Last Name
	2.	Lust Hume
Address:		
City	State	7:
City.	State	Zip
Sex: F M Ema	ail:	
Personal Contact in Cose of Ev		
Personal Contact in Case of Er	nergency:	one: ()
Keiationship:	Pno	one: (
Family Physician.	D . C	DI
ramny i nysician.	Referring	Physician:
How were you referred to our	office?	
*If patient is a minor, please co	mplete the following sect	tion:
*Responsible Party:	implete the following see	non.
*Responsible Party: *Name and address of Employ	OM•	
Name and address of Employ	EI •	
*****	la ala ala ala ala ala ala ala ala ala	*********
PLEASE GIVE INSURAN	NCE CARD(S) TO FE	RONT DESK FOR COPYING
****************	*************	*********
Λssi	gnment of Insurance	Ranafita
submitted on behalf of myself and/or	dependents. I further express	relating to all claims for the benefits
signature on this consent authorizes S	Synergy Hearing to submit cla	ims for benefits, services rendered, or
services to be rendered without obtain	ning my signature on each and	l every claim to be submitted for myself
and/or dependents, and I will be bour	d by this signature as though	the undersigned had personally signed the
particular claim.		the undersigned had personally signed the
The undersigned further aut	horizes the above named insur	rance company/ies to pay directly to
Synergy Hearing, all benefits, if any,	otherwise payable for its servi	ces as described on any submitted claim or
invoice. In the event my insurance do	es not pay for such services, I	understand that I am financially
responsible for all charges incurred.		
Signature of Insured or Authorized P	Date:	/

Pediatric Audiology History

Name:	Ag	e:	Date:
Pediatrician:			
Please send a report to my pediatrician			
Please check and/or describe all that apply bel	ow including	g the age at v	which it occurred.
Pre-Natal (Pregnancy)			Delivery
Length/Term	Dı	ıration/Laboı	r
Illness	C-	Section	
Medications	Po	sition	
Complications			
	Post-Partum	1	
Birth Weight	La	ck of Oxyge	n
Jaundice	Cr	aniofacial A	nomalies
Incubator			
Infan	cy and Chile	dhood	
At what age did your child walk?			
At what age did your child say his first word?			
M	ledical Histo	ry	
High Fevers/Serious Illnesses		и в в в в в в в в в в в в в в в в в в в	
Seizures/Convulsions			
Hospitalizations/Surgeries including tonsillectom	y, adenoidect	omy and/or i	myringotomy with or
without insertion of tympanostomy tubes			
Family history of hearing loss			
S	Social Histor	\mathbf{y}	
Does your child interact well with others his/her of	own age?		
Behavior Problems?	<i>S</i>		
School Grade School Progres	S		
School your child is presently attending		* *	
Name of your child's teacher	2		
(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?							
	es your child have a permanent hearing loss that you are aware of?							
	example: loss in one ear only, can't hear high pitch sounds)							
Ple	ase describe the hearing loss							
Ha	s any member of your family, or your child's teacher, ever expressed concern							
abo	out your child's hearing?							
<u>Sp</u>	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 appear to have difficulty understanding speech in background noise?							
	Has your child had a formal hearing test by an audiologist?							
(not	just a screening at the doctor's office or in school)?							
Spe	ecific 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?							
5.	Has your doctor ever observed fluid behind your child's eardrums? Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)?							
	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?							
	Allergies?Allergies?							
Add	ditional Comments/Observations							
	ditional Comments/Observations:							

505 E. Washington Avenue - Newtown, PA 18940



Acknowledgment of Receipt of Notice

rgrozalis@msn.com

I hereby a	cknowledge	that I have read this medical practices' Notice of Privacy	Practices
Yes	_ No	I wish to receive a copy of the Notice of Privacy Prac	tices
Signed		Date	
Name:		Telephone:	
If not sign	ed by the pa	tient indicate relationship	
Par	rent or guard	lian, if patient is a minor	
		inservator of an incompetent patient	
Be	neficiary or	personal representative of deceased patient	
Name of p	eatient		
For office	use only:		
Signed and	d received by	y	
Acknowle	dgment refu	sed:	
Efforts to	obtain:		
Reasons fo	or refusal:		