STATEN ISLAND AUDIOLOGICAL SERVICES

Please Print Clearly

Patient: **This section refers to the ***patient only*****

Name:_____ Age:____ Date of Birth:_____ Marital Status:_____ Minor_____
Last First

Address:_____ Sex:____ Email address:_____

City:_____ State:_____ Zip:_____ Employer:_____

Home Phone:( )_____ Address:_____

Cell Phone: ( )_____ City:_____ State:____ Zip:_____

Family Member: ( )_____

BILLING: *Please complete if person responsible for bill is other than patient*

Name:_____ Relationship to Patient:_____
Last First

Street Address:_____ Insured's Date of Birth:_____

City:_____ State:_____ Zip:_____ Home Phone:( )_____

Employer:_____ Address:_____

Work Phone:( )_____ City:_____ State:_____ Zip:_____

PLEASE PROVIDE YOUR INSURANCE COVERAGE. If you have more than one carrier, complete information on both.
PLEASE LIST ALL NUMBERS ON YOUR CARD(s).

Primary Company:_____	Secondary Company:_____
Address:_____	Address:_____
Name on I.D.card_____	Name on I.D.card_____
Relationship to patient (Please check)	Relationship to Patient (Please Check)
Self____Spouse____Parent____Other____	Self____Spouse____Parent____Other____
Insured I.D. #:_____	Insured I.D. #:_____
Group #:_____	Group #:_____

Signature_____ Date_____ Referred by_____

PATIENT NAME:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____Date: _____

REQUEST FOR RELEASE OF INFORMATION

I authorize **Staten Island Audiological Services** to release information to the following:

Name: _____
Address: _____

Signature: _____Date: _____

PATIENT'S AUTHORIZATION – CERTIFICATION FORM

INSURANCE CO: _____ID #: _____

I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefit to either myself or the audiologist, if the fee has not been paid. I understand I am financially responsible for any balance not covered by my insurance carrier.

Signature: _____Date: _____

PEDIATRIC AUDIOLOGY HISTORY

NAME: _____ DATE OF BIRTH: _____AGE:_____
Pediatrician/Primary Care Physician:_____
Who referred you to our facility?_____
What is the reason for the referral? _____

School:_____Grade:_____ How is your child doing in school academically? _____
Are there any behavioral issues in school?_____

Pregnancy/Delivery History:

Length of Pregnancy (months/weeks)_____ Birth Weight _____ Type of Delivery_____
Were there any complications? _____
Did the baby stay in the NICU? Y N Did the baby receive any therapy or treatment such as antibiotics, oxygen, blood transfusion, phototherapy etc? Y N If so, please explain_____
Was the baby's hearing tested at the hospital? Y N If so, did the baby pass the hearing screening? Y N

Medical History:

Developmental Delay Y N_____
Speech Delay Y N_____
PDD/NOS or Autism Y N_____
Asperger's syndrome Y N_____
Ear Infections/ Fluid in the ear Y N If so, how many per year?_____
Ear trauma/Hole in Eardrum Y N_____
Tinnitus/Noise in the ear Y N_____
Head trauma Y N_____
Has child seen an ENT doctor? Y N If so, when?_____
Has child had P.E. tubes inserted? Y N If so, when?_____
Hospitalizations Y N_____
Seizures Y N_____
Allergies/Asthma Y N_____
Frequent Colds Y N_____
Snoring/Mouth Breathing Y N_____
High Fevers Y N_____
Syndromes Y N_____
Attention Deficit Disorder Y N If so, is it managed with medication?_____
Family history of permanent hearing loss Y N_____
Has child had his/her hearing tested before? (other than at birth) Y N If so, when?_____
Has child had tonsils or adenoids removed? Y N If so, when?_____
Is child's speech age appropriate? Y N
Has child had a speech/language evaluation? Y N If so, when?_____
Has child had early intervention evaluation? Y N If so, when and where?_____
Does your child receive any of these services? (circle all that apply) Speech Therapy OT PT ABA Counseling Special Instruction Other_____
Has your child ever worn a hearing aid? Y N _____
Does the child wear or ever worn an FM Y N_____
Do you have any concerns about your child's hearing? Y N_____
Does your child respond to sound consistently? Y N_____
Do you need to repeat things in order to be understood? Y N _____
Does your child like the volume of the T.V. raised? Y N _____
ADDITONAL COMMENTS/OBSERVATIONS:_____

_____**PARENT/LEGAL GUARDIAN**