PEDIATRIC HEARING QUESTIONNAIRE

CHILD'S NAME: ______________________________ **DATE OF BIRTH:** ______________

Why did you or your child's doctor think a hearing test is needed today?

☐ Speech Delay ☐ Referred on screening ☐ Pre-Op Test for Ear surgery (ear tubes, etc.)

Other: ____

____

Does your child have any other medical diagnoses? ☐ Yes ☐ No If YES, explain:

____

____

Please check if your child has had any of the following. Briefly explain any that you have checked.

☐ Speech-Language delay ☐ Ear infections ☐ Ear surgery (ear tubes, etc.)

☐ Head trauma/injury ☐ Meningitis ☐ Kidney problems

Other: ____

____

Is there a family history of hearing loss at a young age? ☐ Yes ☐ No ____________________

Does your child consistently respond to your voice? ☐ Yes ☐ No ____________________

Does your child respond to loud noises? ☐ Yes ☐ No ____________________

Does your child search to find where the sound is coming from? ☐ Yes ☐ No ______________

Does your child respond to sounds from other rooms? ☐ Yes ☐ No ____________________

Does your child complain of ear pain? ☐ Yes ☐ No ____________________

Does your child complain of ringing in ears? ☐ Yes ☐ No ____________________

Does your child complain of dizziness? ☐ Yes ☐ No ____________________

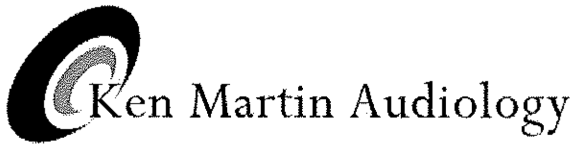
Did your child pass the newborn hearing screening at the hospital? ☐ Yes ☐ No ______________

Was the pregnancy, delivery, or birth history abnormal? ☐ Yes ☐ No If YES, briefly explain:

____

____

X **Signature:**______________________________ **Relation to Patient:**________________ **Date:**__________



Thank you for choosing Ken Martin Audiology for your hearing healthcare needs! We strive to provide the very best service and appreciate referrals of friends and family if you are satisfied with your visit.

PATIENT INFORMATION

PATIENT'S NAME: **GENDER:**

PATIENT DATE OF BIRTH: **AGE:**

MAILING ADDRESS:

CITY, STATE, ZIP:

HOME PHONE #: **CELL #:** **WORK #:**

EMAIL:

REFERRING PHYSICIAN: ____________________ **PRIMARY CARE PHYSICIAN:** ____________

Some insurance plans (ex. Medicare, Medicaid, CHIP, HMO Plans, etc.) will not pay visit fees if you were not referred by your physician. If you do not have a copy of your insurance or referral in place (if required), self-pay discounts may be available.

HOW HAVE YOU HEARD ABOUT KEN MARTIN AUDIOLOGY? Please check one or more:

- ☐ YOUR PHYSICIAN
- ☐ TELEVISION
- ☐ WALK-IN / STREET SIGNAGE
- ☐ NEWSPAPER
- ☐ WEB SEARCH
- ☐ FACEBOOK / SOCIAL MEDIA
- ☐ HOSPITAL
- ☐ SCHOOL
- ☐ YELLOW PAGES
- ☐ FRIEND / ANOTHER PATIENT: ____________________

FOR MINORS, NAME OF THE GUARDIAN/PARENT:

GUARDIAN DATE OF BIRTH:

ADDRESS, CITY, STATE, ZIP:

HOME PHONE #: CELL #: WORK #:

EMAIL:

IF THE PATIENT IS LISTED ON ANOTHER PERSON'S INSURANCE, WE MUST HAVE THE PRIMARY POLICY HOLDER'S NAME AND DATE OF BIRTH:

INSURANCE PRIMARY POLICY HOLDER'S NAME: ____________________

INSURANCE PRIMARY POLICY HOLDER'S DATE OF BIRTH: ____________________

A COPY OF YOUR INSURANCE CARD(S) AND A PICTURE ID IS REQUESTED ALSO.

X **Signature:**____________________ **Relation to Patient:**__________ **Date:**________

AUTHORIZATION FOR TREATMENT

______ By initialing here and signing below, I authorize Dr. Ken Martin, Audiologist, to give the referenced patient reasonable and proper audiology care by today's standards. In the event that I am scheduled to receive ongoing procedures, this consent shall remain in effect until I am discharged.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

______ By initialing here and signing below, I also hereby authorize and direct my insurance carrier to pay directly to Kenneth R. Martin, Jr. any benefits for audiology services rendered to myself/dependent under my insurance plan. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AGREEMENT OR THE INSURANCE I HAVE PROVIDED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

______ By initialing here and signing below, I acknowledge that I received or been offered a copy of Ken Martin Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I give permission for Ken Martin Audiology to call, text, mail, or email me with information, which may include confidential messages being left on my telephone/answering machine.

____
Printed Name of patient or personal representative

____
Signature of patient or personal representative

Date: ______________________________