AUDIOLOGY& HEARING HEALTH
3942A East Tremont Ave, Bronx, NY 10465
Office Phone: (718) 676-9955
audiologyhh@gmail.com

WELCOME TO AUDIOLOGY & HEARING HEALTH

Thank you for contacting us. Your care and privacy is our top priority.

We would appreciate if you would complete the attached forms prior to your visit and bring them with you. Doing so will save you time on the day of your visit.

Please bring the following items with you on the day of your visit:

INSURANCE CARD(S) and PHOTO ID

REFERRALS: If a referral is required for insurance purposes, the information will be found on the back of your insurance card. Please arrange to have the appropriate referral prior to your visit. In most cases, it is necessary to obtain the referral from your primary care physician. If you do not have an appropriate referral on the day of your visit, you must make payment in full and receive reimbursement directly from your insurance carrier.

PRIOR TESTS: If you have results from previous examinations, please bring them with you on the day of your visit.

CO-PAYMENTS: Co-payments are due at the time of your visit.

Helpful Hints: Refer to your insurance card for any questions regarding referral information, coverage or co-payments.

If you have any questions, please feel free to call us at (718) 676-9955 or email us at audiologyhh@gmail.com.

We appreciate you choosing Audiology & Hearing Health for your hearing care needs. We look forward to seeing you at your visit.

Please fill out the following form, it may be printed and handwritten.
Bring completed forms on day of visit.

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PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE _____

PATIENT'S NAME_____
FIRST MIDDLE LAST

DATE OF BIRTH _____ AGE _____ SEX: ____M ____F PATIENTS SSN # _____

NAME OF PARENT/GUARDIAN _____
FIRST MIDDLE LAST

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ EMAIL ADDRESS _____

MAILING ADDRESS_____

CITY _____ STATE_____ ZIP _____

NAME OF ADDITIONAL PARENT/GUARDIAN _____
FIRST MIDDLE LAST

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ EMAIL ADDRESS _____

MAILING ADDRESS_____

CITY _____ STATE_____ ZIP _____

PATIENT'S PRIMARY CARE PHYSICIAN _____ PHONE # _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL _____ RELATION TO PATIENT _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM PATIENT _____ HOME PHONE _____

SUBSCRIBERS EMPLOYER _____ EMPLOYER ADDRESS _____

IS THE PATIENT COVERED BY INSURANCE _____ YES ____ NO

PRIMARY INSURANCE:

PLAN NAME _____POLICY/ID # _____ GROUP #_____

SUBSCIBERS NAME _____ PATIENT RELATIONSHIP TO SUBSCRIBER_____

SUBSCRIBERS DOB _____ SUBSCRIBERS EMPLOYER_____

SECONDARY INSURANCE:

PLAN NAME _____POLICY/ID # _____ GROUP #_____

SUBSCIBERS NAME _____ PATIENT RELATIONSHIP TO SUBSCRIBER_____

SUBSCRIBERS DOB _____ SUBSCRIBERS EMPLOYER_____

RELEASE OF INFORMATION AND PAYMENT GUARANTEE

I, the undersigned, authorize the release of any information required to process claims for insurance or membership benefits submitted on behalf of myself and/or my dependents in connection with this and future visits. I further expressly agree and acknowledge that my signature authorizes AUDIOLOGY & HEARING HEALTH to submit claims for benefits rendered. I understand and accept that I am responsible for payment of any non-covered services or procedures, deductibles, co-pays, and or other co-insurance amounts. I authorize the release of medical or any other information necessary to process my medical claim information to my insurance company, to my physician, and to the following other parties, with the reasons noted.

SUBSCRIBER SIGNATURE _____ DATE _____

I have been given the opportunity to read or obtain a copy of Audiology & Hearing Health Notice Of Privacy Practices (copies are available at the front desk)

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

RELEASE OF PROTECTED HEALTH INFORMATION

Unless otherwise instructed, we will send a report of any hearing evaluation completed to the referring and/or primary care physician.

_____ DO NOT send a report to my referring physician _____ DO NOT send a report to my primary care physician

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PEDIATRIC CASE HISTORY

PATIENTS NAME _____ TODAY'S DATE _____

PEDIATRICIAN _____ REFERRING DOCTOR _____

ADDRESS _____ ADDRESS _____

_____ _____

PHONE # _____ PHONE # _____

BIRTH HOSPITAL _____

BIRTH HISTORY

What is the reason for today's visit? _____

Did the child's mother experience any complications/illness during pregnancy? [ ] Yes [ ] No

If yes, please describe _____

_____

Did the child's mother take medication taken during pregnancy (including antibiotics)? [ ] Yes [ ] No

If yes, please specify _____

Length of Pregnancy _____ Length of Labor _____ Childs Birth Weight_____

Was the child in the NICU (Neonatal Intensive Care Unit)? [ ] Yes [ ] No

If yes, how long was the child in the NICU? _____

Did your child receive oxygen? [ ] Yes [ ] No

If yes, for how long? _____

Did your child receive any known medications/treatments while in the NICU? [ ] Yes [ ] No

If yes, please list _____

Please check any conditions that were present at the time of your child's birth:

[ ] Jaundice [ ] Toxoplasmosis [ ] Seizures [ ] Cytomegalovirus (CMV)
[ ] Breathing Problems [ ] Herpes Simplex [ ] Rubella
[ ] Blood Exchange [ ] Hyperbilirubinemia [ ] Syphilis
[ ] Other _____

Please check if your child has experienced any of the following illnesses or conditions:

[ ] Allergies [ ] Asthma [ ] Colds [ ] Tonsillitis
[ ] Headaches [ ] Dizziness [ ] Tinnitus/noise in ears [ ] Sinusitis
[ ] Pneumonia [ ] Convulsions [ ] Croup [ ] ChickenPox
[ ] Encephalitis [ ] Measles [ ] Mumps [ ] German Measles
[ ] High Fevers [ ] Ear Infections [ ] Draining Ears [ ] Mastoiditis
[ ] Influenza [ ] Meningitis [[Head Injury
[ ] Other _____

MEDICAL HISTORY

Has your child been diagnosed with a syndrome? [ ] Yes [ ] No
If so, please describe _____
Has your child been hospitalized? [ ] Yes [ ] No
If so, please describe _____
If your child currently on medication? [ ] Yes [ ] No
If so, please describe _____
Is there a family history of hearing loss? [ ] Yes [ ] No
If so, please describe _____
Does your child have a vision impairment? [ ] Yes [ ] No
If so, please describe _____
Did your child pass their newborn hearing screening at birth? [ ] Yes [[No
If no, was follow-up testing pursued? _____
Has your child ever received a hearing test? [ ] Yes [ ] No
If yes, where and what results were obtained _____
Has your child ever had ear surgery? [ ] Yes [ ] No
If yes, where and what results were obtained _____
Has your child ever received a speech/language evaluation? [ ] Yes [ ] No
If yes, where and what results were obtained _____
Do you suspect that your child has a hearing loss? [ ] Yes [ ] No
Are you concerned regarding your child's speech production abilities? [ ] Yes [ ] No
Has your child had ear infections? [ ] None [ ] Left Ear [ ] Right Ear [ ] Both Ears
If yes, specify what ages, how many, and how often _____

When was the last ear infection? _____
Has your child ever had "tubes" in his/her ears? [ ] None [ ] Left ear [ ] Right Ear [ ] Both Ears
If yes, specify when and how many times _____
_____

SCHOOL INFORMATION

School Name _____ Grade _____

Does your child receive any special services? [ ] Yes [ ] No
If yes, please describe _____

Does your child currently have an IEP (individualized Education Plan)? [ ] Yes [ ] No
If yes, please describe _____