KAREN M. SCOTT, Au.D.
AUDIOLOGY & HEARING AIDS

REFERRED BY: _____ PRIMARY CARE PHYSICIAN:_____

CHILDREN (0-18) PATIENT INFORMATION:

NAME: FIRST_____MIDDLE _____LAST_____

DATE OF BIRTH _____/_____/_____ AGE_____SEX_____ MISS / MS. / MRS. / MR. (please circle one)

MAILING ADDRESS:_____

CITY_____STATE_____ZIP_____

HOME PH # ( )_____CELL PH #( )_____ WORK PH# ( )_____

EMAIL ADDRESS _____

DOES CHILD LIVE WITH: BOTH PARENTS / MOTHER / FATHER / JOINT CUSTODY / OTHER?

RESPONSIBLE PARTY _____PH# ( ) _____ DATE OF BIRTH _____/_____/_____

ADDRESS IF DIFFERENT FROM CHILD'S:_____

EMPLOYER AND ADDRESS_____

SPOUSE'S NAME_____ WORK PH# ( )_____

TRANSLATOR CONTACT _____ PH# ( ) _____

PLEASE PRESENT YOUR INSURANCE CARD(S) & COMPLETE THE SECTION BELOW.

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

CERT./POLICY/ID#_____ CERT./POLICY/ID#_____

GROUP#_____EMPLOYER_____ GROUP#_____EMPLOYER_____

POLICY HOLDER_____ POLICY HOLDER_____

DATE OF BIRTH _____/_____/_____ DATE OF BIRTH _____/_____/_____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

(PLEASE CONTINUE ON THE BACK)

Did your child pass his/her newborn hearing screen? Yes No

At what hospital? _____

Do you suspect your child has a hearing problem? Yes No

If yes, when did you first suspect a problem? _____

Has the child's hearing been tested before? Yes No

When were the first and last tests?_____Where? _____

What recommendations were made? _____

Are speech and language developing at an age appropriate rate? Yes No

Has a speech-language pathologist been consulted? Who?_____ Yes No

Which do you think is the better ear? Right Left Neither

What is believed to be the cause of the hearing loss? _____

Did the hearing loss happen gradually( ) or suddenly ( )? Does hearing seem to fluctuate? Yes No

Is there any history of childhood hearing loss in the family? Yes No

If yes, then who? _____

Is there a ringing or other noise in the ears? Yes No

Is there any dizziness? When does the dizziness occur? _____ Yes No

Does the child have trouble hearing: TV_____In Groups_____At School_____In Noise_____In Large rooms _____

Does the child hear but have difficulty understanding speech? Yes No

Does the child rely on others to translate for him/her when he/she cannot hear? Yes No

Has the child ever used a hearing aid? Yes No

If yes, complete the following: Type(s)_____ Brand (s)_____

Ear(s) fitted: RIGHT( ) LEFT( ) Date of purchase? _____

Has an ear doctor (ENT) been consulted? Who?_____ Yes No

Has the patient had **ear surgery**? Yes( ) No( ) **ear infections**? Yes( ) No( ) **ear drainage**? Yes( ) No( )

List any medications the patient is taking now:_____

The above information is correct to the best of my knowledge. I, hereby, authorize Karen M. Scott, Au.D., to bill my insurance for services rendered. I authorize Karen Scott to release information needed to determine benefits. I understand that Karen M. Scott, Au.D. may not be contracted with my insurance company, and as a courtesy my insurance company will be billed; however I am responsible for all charges incurred.

Signature _____ Date _____