Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851-3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

PATIENT (PEDIATRIC 4-11 YRS) APPOINTMENT INFORMATION

Dear Parent(s) or Caregiver(s):

Your child is scheduled for an OAE exam at Harbor Audiology. This exam is a painless procedure where hearing is evaluated by sensors that are taped to the child's head while he/she is relaxed. The following instructions must be adhered to in order for the test to be completed without difficulty.

1. It is helpful if your child is in a calm, relaxed state for testing. Reliable results can only be obtained while your child is quiet and still. The Audiologist will work with you during the appointment to help facilitate this.

2. You will be allowed to stay in the room with your child during testing as long as you do not have other young children with you. You may even be able to hold the child while the test is performed should you desire to do so.

3. If your child is sick on the day of the test, please call to reschedule at (253) 851-3932.

4. Please take a few minutes now to fill out the form(s) accompanying this instruction sheet.

5. Normal testing time only takes about 20-30 minutes but we schedule for extra time to allow the child to relax and calm if they are distressed for any reason. If your child will not relax and the test cannot be completed during one appointment, you may be required to reschedule.

If you have any questions please call us at (253) 851-3932 as soon as possible.

Thank you!

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PATIENT INFORMATION

DUE TO HIPAA REGULATIONS, ALL INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES.

LAST NAME:	FIRST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER: - -	
GENDER: ☐ M ☐ F ☐ Other		

PARENT / GUARDIAN CONTACT INFORMATION

MOTHER'S NAME:	DATE OF BIRTH:	SSN#: - -
HOME PHONE:	CELL PHONE:	
EMPLOYER:	WORK PHONE:	
ADDRESS:		
FATHER'S NAME:	DATE OF BIRTH:	SSN#: - -
HOME PHONE:	CELL PHONE:	
EMPLOYER:	WORK PHONE:	
ADDRESS:		
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? ☐ YES ☐ NO		
I AUTHORIZE THIS OFFICE TO DISCUSS MY CHILD'S CARE INFORMATION OR TREATMENT WITH:		
REFERRING PHYSICIAN:	PHONE NUMBER:	

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:
SECONDARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:

Assignment of Benefits

By signing below, you: (1) allow us to submit a claim along with your medical information to your managed care plan, insurance company, or other Program you have identified as potentially providing coverage for hearing aids and service you receive (any of which will be referred to as the "Plan"); (2) allow us to assign your benefits under the Plan for payment directly to us; (3) acknowledge that you understand and agree to pay us for any applicable co-payments, deductibles and co-insurance under your Plan; and, (4) if the plan allows, acknowledge that you understand and agree to pay for the difference between the price of the hearing aid(s) and/or services and the amount of the benefit collected from your Plan.

SIGNATURE:	DATE:

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PEDIATRIC AUDIOLOGY HISTORY

CHILD'S NAME:	DATE OF BIRTH:	TODAY'S DATE:

PERSON COMPLETING FORM:	RELATIONSHIP TO CHILD:
REFERRING PHYSICIAN:	HAS CHILD BEEN SEEN BEFORE? ☐ YES ☐ NO

Do you think your child has difficulty hearing? ☐ YES ☐ NO ☐ SOMETIMES	Which ear? ☐ L ☐ R
When did you notice this problem?	
Did your child pass his/her newborn screening test? ☐ YES ☐ NO ☐ NOT SURE	
Are there concerns about this child's speech/language? ☐ YES ☐ NO	
If yes, what are the concerns?	

Does your child have the following? (Please check all that apply)

Frequent colds or illness	☐ YES	☐ NO	When was most recent?
Frequent ear infections	☐ YES	☐ NO	When was most recent?
Discharge / drainage	☐ YES	☐ NO	Please describe:
Allergy or sinus problem	☐ YES	☐ NO	Please describe:
History of ear surgery	☐ YES	☐ NO	Please describe:
Family history of speech delay	☐ YES	☐ NO	Please describe:
Family history of hearing loss	☐ YES	☐ NO	Please describe:

MEDICAL HISTORY (Please check all that apply)

☐ Allergy / Sinus Problem	☐ Cytomegalovirus (CMV)	☐ Herpes	☐ Rubella
☐ Anemia	☐ Diabetes	☐ High Fever	☐ Scarlet fever
☐ Anoxia / Hypoxia	☐ Genetic Disorder	☐ HIV / AIDS	☐ Seizure Disorder
☐ Blood Disease	☐ Headaches / Migraine	☐ Jaundice	☐ Stroke
☐ Cancer	☐ Head / Face Abnormality	☐ Kidney Problems	☐ Syphilis
☐ Cerebral Palsy	☐ Head Injury	☐ Liver Problems	☐ Thyroid Disorder
☐ Chicken Pox	☐ Heart Abnormality	☐ Measles/Mumps	☐ Toxoplasmosis
☐ Cleft Palate or Lip	☐ Hepatitis (A, B, or C)	☐ Meningitis	☐ Tuberculosis

Other:

Pregnancy / Birth History:

Please Check One

1. Did the child's mother have any problems or serious illnesses during pregnancy? ☐ Yes ☐ No ☐ Unknown
2. Was the child's mother taking any drugs, alcohol, or medications during pregnancy? ☐ Yes ☐ No ☐ Unknown
3. Were there any problems encountered by the mother or child during delivery? ☐ Yes ☐ No ☐ Unknown
4. Was the child born premature? ☐ Yes ☐ No ☐ Unknown
5. Was the child born via cesarean (C-section) delivery? ☐ Yes ☐ No ☐ Unknown
6. Is the child a twin / triplet? ☐ Yes ☐ No ☐ Unknown
7. Did the child appear yellow (jaundiced) or blue (hypoxia) at birth? ☐ Yes ☐ No ☐ Unknown
8. Was the child's weight low at birth (less than 1.5kg or 3.5lbs)? ☐ Yes ☐ No ☐ Unknown
9. Was the child given oxygen after birth for any reason? ☐ Yes ☐ No ☐ Unknown
10. Was the child kept in the intensive care unit after birth for any reason? ☐ Yes ☐ No ☐ Unknown

Developmental History:

1. Have the child's developmental milestones been age appropriate? ☐ Yes ☐ No ☐ Unknown
2. Has the child been diagnosed with an expressive / receptive speech delay? ☐ Yes ☐ No ☐ Unknown
3. Are there multiple languages spoken in the home? ☐ Yes ☐ No ☐ Unknown
4. Has the child been diagnosed with autism / pervasive development disorder (PDD)? ☐ Yes ☐ No ☐ Unknown
5. Has the child been diagnosed with Down syndrome? ☐ Yes ☐ No ☐ Unknown
6. Has the child been diagnosed with ADD / ADHD? ☐ Yes ☐ No ☐ Unknown
7. Is the child currently being evaluated for any developmental or social problems? ☐ Yes ☐ No ☐ Unknown
8. Is the child receiving any therapy (speech, physical, developmental)? ☐ Yes ☐ No ☐ Unknown

SURGICAL HISTORY (please list any surgeries and/or operations your child has had)

MEDICATIONS (please list your child's current medications and what they are for)

NOTES (PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

Reference Criteria

1. Visible congenital or traumatic deformity of the ear
2. Visible evidence of impacted cerumen or foreign body in canal
3. Otitis Media/history of active drainage from the ear within 90 days
4. Hearing loss (Initial Diagnosis)
5. History of sudden hearing loss/progressive hearing loss within 90 days
6. Unilateral hearing loss of sudden or recent onset within 90 days
7. Conductive hearing loss: Audiometric A-B gaps > 15dB at 500-2000Hz
8. Otalgia or ear discomfort
9. Inflammation of the ear
10. Acute or chronic dizziness (balance disturbance)
11. Tinnitus-Initial evaluation/recent onset
12. Blocked feeling in ear
13. Spontaneous nystagmus
14. Symptoms associated with ototoxic drugs
15. Perforated tympanic membrane

Audiologist Initials: _____