

Project TALK/Pediatric Hearing Specialists

2210 Encinitas Blvd. Ste O ~ Encinitas, CA 92024

(760) 634-1553

PATIENT INFORMATION FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS (IF DIFFERENT): _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

CELL PHONE: _____ OCCUPATION _____

EMPLOYER _____ EMPLOYER'S ADDRESS: _____

MOTHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS (IF DIFFERENT): _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

CELL PHONE: _____ OCCUPATION _____

EMPLOYER _____ EMPLOYER'S ADDRESS: _____

SIBLINGS/AGES: _____

PLEASE INDICATE (x) PARTY TO BE BILLED FOR SERVICES RENDERED:

____ Self Pay ____ Scholarship ____ School district (please note name of district)

____ Insurance (please complete ALL information below or we will not bill insurance):

NAME OF FAMILY MEMBER WHO CARRIES THE INSURANCE: _____

ID # _____ GROUP NUMBER: _____

INSURANCE COMPANY NAME: _____

BILLING ADDRESS: _____

INSURANCE COMPANY TELEPHONE: _____

I authorize the release of any medical or other information necessary to determine eligibility and to process claims. I authorize payment of medical benefits to Project TALK/Pediatric Hearing Specialists. I accept that I am ultimately financially responsible for all services received.

Signature of Patient or Parent/Guardian (if under 18) Date

CASE HISTORY

A. PRE-NATAL HISTORY

1. What was the condition of the mother's health during pregnancy? _____
2. What drugs were taken during pregnancy? _____
3. Did the mother have any of the following during pregnancy: ___ fever; ___ high blood pressure; ___ diabetes; ___ toxemia; ___ Rubella (German measles); ___ CMV; ___ Rh incompatibility? _____

B. BIRTH HISTORY

1. What was the length of pregnancy? _____
2. What was the duration of labor? _____ What type of delivery? _____
3. What was the birth weight? _____ birth length? _____
4. Did your baby have any of the following? ___ jaundice; ___ anoxia (lack of oxygen); ___ birth injury; ___ blood transfusion. _____
5. Were there any breathing, feeding, sucking or swallowing difficulties? _____
6. How long was the baby's hospital stay? _____ If the hospital stay was longer than normal, what treatments did your baby receive? _____
7. Did your baby receive newborn hearing screening prior to discharge from the hospital? _____ If so, what test was done and what were the results? _____

C. HEALTH HISTORY

1. Please indicate the date your child had any of the following illnesses: ___ Chicken pox; ___ Scarlet Fever; ___ Whooping Cough; ___ Cerebral Palsy; ___ Mumps; ___ Rubella; ___ Rubeola; ___ Meningitis; ___ Asthma; ___ Head Injury; ___ Convulsions; ___ Dizziness; ___ High Fever. _____
2. Has your child been hospitalized for any reason? (Explain) _____
3. Does your child have eye problems and/or wear glasses? _____
4. Are there any other health problems other than hearing loss? (Explain) _____

D. HEARING HISTORY

1. When was the hearing loss suspected? _____
2. Who suspected it and why? _____
3. What action was taken? (Include names, dates, tests) _____
4. What do you think caused the hearing loss? _____
5. Is there any hearing loss in your family? _____
6. Did you and/or your child receive genetic counseling or testing? _____ If so, what were the results? _____
7. When was the child fitted with hearing aids? _____ What type of hearing aids? _____
8. What was your child's response to hearing aids? _____
9. Does your child have a cochlear implant? _____ When was your child implanted? _____ Where was your child implanted? _____ Surgeon's name? _____

Audiologist's name? _____ Type of implant? _____

Which ear was implanted? _____ Does your child wear a hearing aid with the implant? _____

10. What was your child's response to the cochlear implant? _____

11. Does your child have a history of ear infections? _____

12. Does the hearing seem to fluctuate? _____

13. How many hours per day does your child wear his hearing aids and/or implant? _____

14. What are your current concerns with your child's hearing aids and/or implant? _____

15. Does anyone in your family have a speech, language, and/or learning disability? _____

E. CHILD'S DEVELOPMENT

1. When did your child: sit _____; crawl _____; walk _____?

2. Is your child toilet trained? _____

3. Does your child favor one hand? _____ Which one? _____

4. What is your child's best time of day? _____

5. How are his sleeping habits? _____

6. Is he restless or overactive? _____

7. What behavior problems do you encounter? _____

8. What is your method of discipline? _____

9. How would you describe your child's temperament? _____

10. To what sounds does your child respond? _____

11. What sounds does he babble? _____

12. What words does he understand? _____

13. What words does he say? _____

14. Does he use sentences? _____ Give an example: _____

15. How does he communicate his needs? _____

16. How do you communicate with him? _____

17. What is your biggest frustration in communicating with your child? _____

18. In what areas does your child appear advanced? _____

19. In what areas does your child appear delayed? _____

20. Is your child receiving services to assist with other areas of development? _____ If so, what? _____

21. Do you have any specific concerns about your child's development? _____

F. GENERAL INFORMATION

1. In what educational programs is your child involved? _____

2. How many hours a day does he watch TV? _____ What shows? _____
3. How many hours does he sleep at naps? _____ At night? _____ How often does he wake during the night? _____ What is his typical bedtime? _____ What time does he typically wake? _____
4. How are his eating habits? _____
5. Is your child currently taking any medication? _____ What medication and why? _____
6. What are your child's current play interests? _____
7. How does your child respond to his peers? _____
8. What types of play does your child do with his peers? _____
How does he communicate with his peers? _____
9. What is your primary concern for your child? _____
10. Is there any other information which would be important for helping your child? _____
11. How did you hear of my services? _____

All of the above answers on the Patient Information Form and Case History Form are true and complete according to the best of my knowledge and belief.

Signature of Parent/Guardian

Date