Pediatric Patient Information Form

Last Name: ____________________ First Name: ________________________ MI: ______

Date of Birth: __________ Age: ___ Sex: _______ Email of Parent: ______________________

Parent/Guardian Name: ______________________ Relation to Child: ____________________

Parent/Guardian Name: ______________________ Relation to Child: ____________________

Parent/Guardian Home Phone #: _____________ Cell #: ___________ Work #: _____________

Mailing Address: ____

City: _________________________________ State: _________________ Zip Code: ______

Child's School: __________________ School Address: _______________________________

Family Physician: ____________________________________ Phone #: ________________

Physician's Address: ____

Emergency Contact: ______________ Relation: ______________ Phone #: _______________

Whom may we thank for referring you to our office? _____________________________________

Reason for Visit: ____

Primary Insurance Company: _______________________ Policy ID #: ____________________

Name of Policyholder: _______________________ Policyholder Date of Birth: _______________

Secondary Insurance Company: _____________________ Policy ID #: ____________________

Who is financially responsible for this visit? _______________________ Phone #: ____________

I authorize **Sound Advice** to release information requested with regard to processing my claims. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify **Sound Advice** of any changes in my health status or in the above information.

____ ____________________

Signature of responsible party: Date:

Pediatric Patient Medical History Form

Child's Name: ____

Please answer the following:

Has your child's hearing been tested before? ☐ Yes ☐ No

Has your child had earaches, ear infections or ear discharge? ☐ Yes ☐ No

If yes, has your child received treatment? ☐ Yes ☐ No

Do other members of your family have hearing problems? ☐ Yes ☐ No

Does your child have hearing difficulties? ☐ Yes ☐ No

Are you concerned with your child's speech development? ☐ Yes ☐ No

Has your child ever seen an ENT (ear doctor)? ☐ Yes ☐ No

Has your child undergone any surgeries? ☐ Yes ☐ No

If yes, please list: ____

Is your child being treated for any medical condition(s) or educational problem(s)? ☐ Yes ☐ No

If yes, please list: ____

Is your child taking any medication(s)? ☐ Yes ☐ No

If yes, please list: ____

Insurance Alert

I, ____ , acknowledge that Sound Advice has contacted my health insurance company as a courtesy.

Benefits that are quoted for audiologic services or hearing instruments rendered at this office **do not** guarantee payment. Sound Advice shall not be held liable for inaccurate information quoted by my insurance carrier or deductibles that have yet to be met by the insured person.

We strongly urge our patients to obtain the exact and maximum benefit allowable in writing by their current health care plan. This is invaluable should any questions arise.

Please understand that we strive to provide you with the best services possible. We will be happy to bill your health carrier for our services; however, we cannot represent you should your health coverage fail to complete the verbally quoted reimbursement amount.

____ ______________________________

Signature of Insured Date

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read the Notice of Privacy Practices for Sound Advice.

I would like to receive a copy of any amended Notice of Privacy Practices by email at:

____

Signed: ______________________________________ Date: ______________

Print Name: ________________________ Telephone: ____________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of a minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of a deceased patient

Name of Patient: ____

For Office Use Only

☐ Signed form received by: ____

☐ Acknowledgement refused:

- Efforts to obtain: ______________________________
- Reason for refusal: ______________________________