POTOMAC AUDIOLOGY

Doctorate-level hearing care you can trust

Child History Form

One Central Plaza
11300 Rockville Pike Suite 105
Rockville MD 20852
240-477-1010

Child's Name: _____ Today's Date: _____

☐ **Female** ☐ **Male** ☐ **Prefer not to specify**

Date of Birth: ____/____/____ Current Age: _____

How did you find us? **Physician referral (name): _____**

Current Patient (name):_____Website:_____

Internet search☐ **Social Media Site _____**

Contact Information:

Parent/Caregiver's Name: _____

Parent/Caregiver's Date of Birth:_____/_____/_____

Telephone (Home) _____ Telephone (Cell) _____

Email address: _____

Mailing Address: _____

_____

How would you like to be contacted about appointment reminders?

Text Message☐ **Phone Call** ☐ **Email**☐

We would like a **copy of our findings** sent to your primary care physician to keep she/he informed of your care. Please provide the contact information:
If you prefer we do not send the results/report, please check here: ☐

_____

_____

Hearing History

1. Explain **concerns** you have about your child's hearing abilities:
   _____
   _____
   _____

2. Did your child have a **newborn** hearing screening? ☐ Yes ☐ No ☐ Don't know

3. Has your child's **hearing been tested** previously (beyond the newborn screening)? ☐ Yes ☐ No ☐ Don't know
   If yes, please identify the date of the test and the results (if known):
   _____
   _____

4. Does anyone in your **family** have a hearing loss that started before the age of 30?
   ☐ Yes ☐ No ☐ Don't know
   If yes, please explain: _____

5. Does your child **consistently respond** to your voice? ☐ Yes ☐ No ☐ Not sure

6. Does your child/infant **startle** to loud noises? ☐ Yes ☐ No ☐ Not sure

7. Does your child have **trouble hearing at school**? ☐ Yes ☐ No ☐ Not sure

8. Does your child have any **speech and language** difficulties?
   ☐ Yes ☐ No ☐ Not sure
   If yes, please explain_____

_____

_____

9. Does your child use **hearing aids** and/or any assistive listening devices?
   ◯Yes ◯No If yes, please explain: _____ _____
   _____
   _____

Medical History

10. Were there any **complications** at birth? ◯Yes ◯No ◯Don't know
    If yes, please explain: _____
    _____

11. Does your child have ongoing **medical issues**? ◯Yes ◯No
    If yes, please explain: _____
    _____

12. Please check if your child has any of the following:
    Meningitis☐ Allergies☐ Kidney problems☐ Measles☐
    Mumps☐ Vision problems☐ Movement problems☐

13. Has your child had **ear infections**? ◯Yes ◯No
    If yes, please describe: _____

14. Has your child had **ear surgery** (to include ear tubes)? ◯Yes ◯No
    If yes, please describe: _____

15. Does your child lose her/his **balance** or fall easily? ◯Yes ◯No ◯Not sure

16. Is your child taking any **medication**(s)? ◯Yes ◯No
    If yes, please describe: _____

If you did not bring your insurance cards with you, please ask for an insurance form.

Your insurance may not cover all your costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for those services. Some costs are covered, however exceed the negotiated rate or allowable rate based on your individual insurance plan. The negotiated rate is the amount Potomac Audiology will be paid by the insurance companies per our contract. This may differ from the allowable amount indicated by your insurance plan.

I understand that I am responsible for my estimated deductible, co-insurance, co-pay, upgrade, and any portion my insurance does not pay.

Signature:_____Date:_____

Please bring your insurance cards and ID so we may make a copy

Primary Insurance:
ID Number:

Policy Holder:
Group Number:

Secondary Insurance:
ID Number:

Policy Holder:
Group Number:

Relationship to Patient if other than "Self":
Date of Birth of Insured: