Island Audiology & Hearing Aid Centers

Pediatric Patient Information Form

Last Name_____ First Name_____MI_____

Date of Birth_____ Sex: ☐ **M** ☐ **F**

Parent/Guardian Name:_____

Email_____

Primary Phone # _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone # _____ ☐ Home ☐ Cell ☐ Work

How would you like to be contacted? ☐ Call ☐ Text ☐ Email

Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Phone # _____

Fax # _____

Referring Physician_____Phone#_____

(If different from Primary) Fax # _____

PRIMARY INSURANCE INFORMATION:

Insurance Company:_____ Subscriber ID#:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Relationship to Insured: ☐ Self ☐ Child Other_____

Other Insurance: ☐ Yes ☐ No

Insurance Company:_____ Subscriber ID#:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Relationship to Insured: ☐ Self ☐ Child Other_____

Who can we release information to:

Name:_____Name:_____

Relationship:_____Relationship:_____

Phone Number:_____Phone Number:_____

Emergency Contact ☐ Yes ☐ No Emergency Contact ☐ Yes ☐ No

What brings your child in today?_____

How did you hear about us?_____

☐ Patient Referral ☐ Newspaper ☐ Direct Mail ☐ Physician Referral ☐ Yellow Pages ☐ Online

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Pediatric History Form

Patient's Name: _____ Today's Date:_____

■ What is the main reason your child is here today?

_____

_____

Hearing History

■ Do you have any concerns about your child's hearing? ☐ Yes ☐ No
- If yes, briefly explain: _____

■ Does your child seem to hear better some days than others? ☐ Yes ☐ No

■ Does anyone in your child's immediate or extended family have a hearing loss that started before the age of 30? ☐ Yes ☐ No
- If yes, what is their relationship to your child?_____

■ Does your child wear hearing aids or assistive listening devices? ☐ Yes ☐ No

Pregnancy and Birth History

■ Was the pregnancy/delivery of your child abnormal in any way? ☐ Yes ☐ No
- If yes, briefly explain: _____

■ Did your child stay in the NICU for any duration after birth? ☐ Yes ☐ No

■ Was there a history of STD or drug use during pregnancy? ☐ Yes ☐ No
- If yes, briefly explain: _____

■ Did your child pass the newborn hearing screening? ☐ Yes ☐ No

Speech/Language History

■ Do you have any concerns about your child's speech or language? ☐ Yes ☐ No
- If yes, briefly explain: _____

■ Is your child currently receiving speech therapy? ☐ Yes ☐ No

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Pediatric History Form

Medical History

- Has your child ever been hospitalized? ☐ Yes ☐ No
  - If yes, what for?: _____
- Does your child have a history of ear infections? ☐ Yes ☐ No
  - If yes, which ear?: _____
- Does your child have a history of ear surgery? ☐ Yes ☐ No
  - If yes, which ear? _____
  - Type of surgery? _____ Date of surgery? _____
- Is your child on any medications? ☐ Yes ☐ No
  - If yes, please list: _____
- Does your child have any allergies? ☐ Yes ☐ No
  - If yes, please list: _____
- Does your child have/has your child ever had any of the following? (Please check all that apply)

☐ Head Trauma/Injury	☐ Chicken Pox	☐ Dizziness	☐ Noise exposure
☐ Heart Problems	☐ Usher's Syndrome	☐ Meningitis	☐ Kidney Problems
☐ Down's Syndrome	☐ Measles	☐ Vision Problems	☐ Tonsillitis
☐ Mumps	☐ Asthma	☐ Seizures	☐ Encephalitis
☐ High fever			

☐ Cancer *Type:* _____ ☐ Radiation ☐ Chemotherapy

☐ Other: _____

Additional Questions

- Do you have any other concerns about your child? ☐ Yes ☐ No
  - If yes, briefly explain: _____
- Does your child:
  - Play/interact well with other children? ☐ Yes ☐ No
  - Have attention/concentration difficulties? ☐ Yes ☐ No
  - Receive any special education services? ☐ Yes ☐ No
  - Have difficulty in school? ☐ Yes ☐ No
  - Have delayed physical or mental development? ☐ Yes ☐ No
- Is your child okay with having his/her ears touched? ☐ Yes ☐ No
- What is your child's favorite animated character? _____
- Any additional comments or concerns? _____

_____

_____

Island Audiology & Hearing Aid Centers

AudigyCertified™

"Hear Better. Live Better"

PATIENT CONSENT FORM

With my consent and signature, Island Audiology and Hearing Aid Centers may use and disclose protected health information about me or my child to:

- Carry out treatment, payment, and healthcare operations (services).
- Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, etc.).
- Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc).
- Send or transmit email to any location provided by me for all above similar items and purposes.
- To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, and specialty physicians. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me.

Consent for Audio/Video Recordings/Telehealth Services:
Island Audiology is a training facility that may require audio/video recordings of appointments for quality assurance and training purposes. Telehealth involves transmission of video, photographs, and/or details of my medical record and test results (collectively, "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth encounter, and have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telehealth services at any time and request alternate service such as in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth service.
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled.

I have the right to review the Notice of Privacy Practices of Island Audiology and Hearing Aid Centers. I may request a copy at any time. I understand that I may request in writing that Island Audiology and Hearing Aid Centers restrict how my or my child's private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Island Audiology and Hearing Aid Centers is not required to agree to my requested restrictions. If agreed, then Island Audiology and Hearing Aid Centers is bound to abide by such restrictions.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Island Audiology and Hearing Aid Centers, may decline further treatment of me or my child.

Patient's Name _____

Signature _____ Date _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other_____
(please specify)

HONOLULU	KAUAI	MAUI	KONA	HILO
1601 Kapiolani Blvd. Suite 950	2970 Kele Street Suite 207	140 Hoohana Street Suite 206	73-5618 Maiau Street Suite A203	784 Kinoole Street
Honolulu, HI 96814	Lihue, HI 96766	Kahului, HI 96732	Kailua-Kona, HI 96740	Hilo, HI 96720
Phone & Fax:	Phone & Fax:	Phone & Fax:	Phone & Fax:	Phone & Fax:
808.955.4327	808.631.1457	808.250.0703	808.329.0943	808.329.0943

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