

# Pediatric Case History Form

a member of **AUDIGY GROUP**<sup>SM</sup>

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Accompanied By: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

### Prenatal Hx:

Maternal Illness: \_\_\_\_\_

Medications: \_\_\_\_\_

Alcohol/Drug/Smoking Use: \_\_\_\_\_

### Postnatal Hx:

Delivery:  Normal  C-Section

Full Term  Premature

Prolonged Hospitalization: \_\_\_\_\_

IV Antibiotics: \_\_\_\_\_

Jaundice/Ventilator/Transfusion: \_\_\_\_\_

Medical Conditions Diagnosed: \_\_\_\_\_

Newborn Hearing Screening: \_\_\_\_\_

Speech Language Development: \_\_\_\_\_

General Development (meeting milestones): \_\_\_\_\_

Number of Ear Infections Since Birth: \_\_\_\_\_ How Treated: \_\_\_\_\_

Family History of Hearing Loss: \_\_\_\_\_

Accidents/Injuries/Illnesses: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

General Health: \_\_\_\_\_

Previous Hearing Evaluations: \_\_\_\_\_

Parental Concern(s) re: Hearing: \_\_\_\_\_

Performance in School: \_\_\_\_\_

Additional Comments: \_\_\_\_\_



**HEARING ASSESSMENT  
CENTER, INC.**

[www.hearingassessment.com](http://www.hearingassessment.com)

The Galleria | 1407 York Rd, Ste 201, **Lutherville**, MD 21093 | **410.583.7021**  
Osler | 7600 Osler Drive, Ste 207, **Towson**, MD 21204 | **410.321.7638**  
Bel Air | 2014 Tollgate Rd, Ste 109, **Bel Air**, MD 21015 | **410.569.8884**  
Franklin Square | 9101 Franklin Square Dr, Ste 305, **Baltimore**, MD 21237 | **410.238.2353**

Revised 07/09

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## Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas.

Location and accessibility	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Adequate parking	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Convenience of appointment times	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Friendly greeting	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Clean and welcoming environment	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor

What can we do to make your next visit more comfortable?

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\*\*\*\*\***PLEASE READ CAREFULLY AND SIGN BELOW**\*\*\*\*\*

- I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my child's medical record and other related information, to my child's insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my child's account for professional services or purchases rendered.
- I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my child's concerns.

**I have read and understand all the above information.**

\_\_\_\_\_  
A copy of this signature is as valid as the original.

\_\_\_\_\_  
Date

Signature of Parent or Guardian if patient is a minor: \_\_\_\_\_