Hearing & Balance Associates
Experience Life Hearing Every Moment

1818 Miccosukee Commons Drive, Tallahassee, FL 32308
Ph.: (850)553-4327 | fax: (850)877-3084
info@hbatallahassee.com | www.hbatallahassee.com

HEARING EVALUATION - CHILD

PATIENT HISTORY

☐ Male ☐ Female *(Please write legibly)*

Name		Date of Birth (mm/dd/yyyy)	Age
Street Name	City	State	ZIP Code
Accompanied by:		Relationship	
Home Phone		Cell Phone	
E-mail Address	Pediatrician/ Primary Care Physician		Provider:
Mother/Guardian name		Occupation	
Employers Name & Address			
Business Phone #		Is it OK to call at work:	
Father/Guardian name		Occupation	
Employers Name & Address			
Business Phone #		Is it OK to call at work:	
Primary reason for this appointment			
Emergency Contact:	Relationship		Phone Number

HEALTH INSURANCE INFORMATION

Primary Insurance:	ID#:
Primary Policy holders name:	Relationship to patient:
Policy holders date of birth:	Social Sec. #
Secondary Insurance:	ID#:
Secondary Policy holders name:	Relationship to patient:
Policy holders date of birth:	Social Sec. #:

IMPORTANT!

Insurance and Referrals:
Most insurance companies have some hearing benefits, but some do not. It is your responsibility to contact your health insurance company to find out whether your child has coverage for hearing evaluation. If your insurance requires a referral for treatment you are also responsible for obtaining that referral. You will be held financially responsible for the charges associated with your child's visit if you fail to obtain a referral or if your child does not have hearing evaluation benefits.

Hearing & Balance Associates, LLC

Patient Name:	Date of Birth:
Address:	City/St/Zip:
SS#:	Phone #:

INSURANCE AGREEMENT

AUDIOLOGIST NOTICE

We will be happy to file your insurance for your hearing evaluation. However, if the insurance company denied payment, the patient is responsible for the balance due.

BENEFICIARY AGREEMENT

I have been notified by my audiologist that his office will file the insurance on my behalf. However, if the insurance company denies payment or it goes to my deductible, I agree to be fully responsible for payment.

AUTHORIZATION AGREEMENT

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that **I received a copy of Hearing & Balance Associates of NW Florida's Notice of Privacy Practices**. I further acknowledge **that a copy of the current notice will be posted in the reception area**, the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment

- This Notice informs me how Hearing & Balance Associates of NW Florida will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Hearing & Balance Associates of NW Florida may use and share my health information for other than treatment, payment, and health care operations.
- Hearing & Balance Associates of NW Florida will also use and share my health information as required/permitted by law.

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

I request and authorize **Hearing & Balance Associates of NW Florida** to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to Hearing & Balance Associates of NW Florida releasing protected health as detailed below.

☐ I prohibit Hearing & Balance Associates of NW Florida from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

____

For the purpose of: ____

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

I authorize *Hearing & Balance Associates* to send me educational information and/or marketing materials related to office promotions, new products and services that may become available.
Only if you do NOT want to receive promotional information such as newsletters, flyers etc. initial here. ______
We are a training facility; therefore, at times patient visits may be videotaped or recorded for training purposes.
Only if you do NOT wish to be videotaped or recorded please initial here. _______

____
PRINTED NAME of patient or personal representative

____ _____________________________
SIGNATURE of patient or personal representative **Date**

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MEDICAL/HEALTH HISTORY

Patient Name:	Date of Birth:	Age:
Address:	City/St/Zip:	
Pediatrician/Primary Care Physician:	Phone #:	

Family History

Were parents relative before marriage Yes No
Family history of kidney disease Yes No
Family history of thyroid problems Yes No
Family history of progressive blindness Yes No
Family history of previous stillbirths or miscarriages Yes No
Family history of hearing loss Yes No
Another affected child in family Yes No
____

Maternal Factors

Drugs (including antibiotics) Yes No
Specify ________________________________
Exposure to chemicals Yes No
Specify ________________________________
Amniocentesis Yes No
Rh immunoglobulin given/Rh of ABO incompatible Yes No
Maternal illness during pregnancy Yes No
Specify ________________________________
Bleeding Yes No
Anemia Yes No
Diabetes Yes No
Toxemia Yes No
Paternal illness during pregnancy Yes No
Specify ________________________________
During pregnancy, mother exposed to:
Measles Yes No
Mumps Yes No
Chickenpox Yes No
German Measles Yes No
During pregnancy, mother diagnosed with:
Syphilis Yes No
Herpes virus Yes No
Influenza Yes No
Cytomegalovirus (CMV) Yes No
Toxoplasmosis Yes No
Other
Specify ________________________________
____
____

Delivery/Labor

Full-term pregnancy Yes No
Labor induced Yes No
Labor less than 3 hr Yes No
Labor less than 24 hr Yes No

Infant/Newborn Factors

Small Birth Weight (< kg/k lb.) Yes No
Birth Weight (lb. /oz.) _____________
Apgar low at birth Yes No
In an intensive care unit Yes No
How long (wk.) _____________
Breathing problems Yes No
Oxygen given Yes No
How long (wk.) ___________
Bilirubin > 15mg/100ml Yes No
Congenital rubella Yes No
Defect of ear, nose, throat Yes No
Specify ___________________________
Congenital heart disease Yes No
Drugs (including antibiotic) Yes No
Specify ___________________________
Exposure to chemicals Yes No
Specify ___________________________
Exposure to radiation Yes No
Specify ___________________________
Paralysis Yes No
Seizures Yes No
Septicemia Yes No

Infant/Childhood

Cognitive impairment Yes No
Eye problems Yes No
Balance/gait/incoordination
Dizziness problems Yes No
Cerebral palsy Yes No
Seizures Yes No
Head trauma/skull Yes No
Ever Hospitalized for:
Meningitis Yes No
Encephalitis Yes No
Measles Yes No
Influenza Yes No
Rubella Yes No
CMV Yes No
Chicken Pox Yes No
Septicemia Yes No
Diabetes Yes No
Sickle Cell Disease Yes No
Other (including conductive Loss)
Specify ___________________________
____

Cesarean Section Yes No
Other Yes No
Specify ___________________________
____
____