AUDIO ACOUSTICS HEARING CENTERS
2101 N. Midland Drive, Suite 4, Midland, TX 79707
(432) 689-4327
***PLEASE TELL THE RECEPTIONIST IF YOU HAVE BEEN HERE BEFORE**

# CASE HISTORY FORM (CHILD)

## Patient History

(Please Print) _____Male _____Female Date:_____

Patient Name:_____ Date of Birth:_____

Home Address:_____ Social Security #:_____

City, State:_____ Zip:_____ Home Phone:_____

Patient's Employer:_____ Business Phone:_____

Name of Spouse:_____ Cell Phone:_____

Parent's Name (if patient is a child):_____

Insured's Name:_____ Insured's Date of Birth:_____

Insurance Co.:_____ Group/Policy #:_____

Insured's I.D. #:_____ Insured's Employer:_____

Person or Agency responsible for payment:_____

Referral Doctor:_____

## Permission for Release of Information

Copy of testing should go to:

1. _____ 2._____ 3._____

I authorize AAHC to release audiological records to those persons/agencies listed above.

Signature:_____

## RESPONSIBILITY OF ACCOUNT

Notice: Audio Acoustics Hearing Centers will file claims for patients with Medicare & Medicaid ONLY. Patients with Medicare are responsible to pay any co-payment or deductible, after Medicare has made payment. Patients with other insurance must pay their balance in full at the time services are rendered, unless prior arrangements have been made. The insurance should be responsible to you for reimbursement. This office is not responsible to collect your Insurance claim or for negotiating a settlement on a disputed claim. We will file your insurance as a courtesy.

I hereby acknowledge and understand that I am responsible for all of the charges for services rendered. I agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

Signature:_____

## HEARING

| | | YES | NO |
|---|---|---|---|
| 1. | Do you think your child has a hearing problem? ..... | ____ | ____ |
| 2. | When did you first suspect there was a problem _____ | | |
| 3. | Did your child have any *ear problems before age 1..... | ____ | ____ |
| 4. | Has your child ever had: earaches? ..... | ____ | ____ |
| | ear drainage?..... | ____ | ____ |
| | how often?..... | ____ | ____ |
| 5. | Has your child ever had tubes placed in his/her eardrums?..... | ____ | ____ |
| | how many times?_____ | | |
| | at what age (s) _____ | | |
| 6. | Does anyone your family have a hearing loss?..... | ____ | ____ |
| | Who?_____ | | |
| | Age identified?_____ | | |
| 7. | Are the child's responses to sounds consistent?..... | ____ | ____ |
| 8. | Does your child's hearing loss seem to fluctuate?..... | ____ | ____ |
| 9. | Has your child's hearing been tested at school?..... | ____ | ____ |
| | When?_____ | | |
| | Results?_____ | | |

## SPEECH & LANGUAGE

| | | | |
|---|---|---|---|
| 1. | Do you think your child's speech & language is normal?..... | ____ | ____ |
| | Explain:_____ | | |
| | If no, is your child receiving speech & language therapy?..... | ____ | ____ |
| 2. | Is your child's voice loud?..... | ____ | ____ |
| 3. | Does your child have reading problems?..... | ____ | ____ |

***Ear Problem:** ear infection, earaches, draining ears, medicine taken for ears, doctor noticed fluid behind eardrum, hole in eardrum, etc.

## MEDICAL HISTORY

| | | YES | NO |
|---|---|---|---|
| 1. | Has your child been seen by an ear doctor (Otologist/ENT)?..... | _____ | _____ |
| 2. | If yes, what doctor _____ | | |
| | Month/year of last visit _____ | | |
| 3. | Does your child have frequent colds or upper respiratory infections?..... | _____ | _____ |
| 4. | Does your child have allergies?..... | _____ | _____ |
| 5. | Has your child had any of the following illnesses?..... | | |
| | Measles_____ Mumps_____ Chicken Pox_____ High Fevers_____ | | |
| | Scarlet Fever_____ Meningitis_____ Encephalitis_____ | | |
| 6. | Is your child presently taking any medications?..... | _____ | _____ |
| 7. | Did the mother have any of the following during pregnancy?..... | | |
| | German measles_____ Rubella_____ STD_____ CMV_____ | | |
| | Other (please explain)_____ | | |
| 8. | Were there any complications during this pregnancy?..... | _____ | _____ |
| | Explain_____ | | |
| 9. | Were there any complications during delivery/birth?..... | _____ | _____ |
| | Explain_____ | | |
| 10. | Length of pregnancy?_____ | | |

## EDUCATIONAL

1. School Attending_____ Grade_____
2. Are your child's grades average, below average or above average?_____
3. Any behavior problems in school?..... _____ _____

## NOISE EXPOSURE

| | | | |
|---|---|---|---|
| 1. | Is your child exposed to loud noises?..... | _____ | _____ |
| | (i.e. farm machinery, shop tools, etc.)..... | | |
| 2. | Does he/she hunt or shoot firearms?..... | _____ | _____ |