Hearing Associates of Northern Virginia

Child Case History

PATIENT INFORMATION

Last Name: _____ First Name: _____MI: _____

Date of Birth: _____ Age: _____ Gender: _____

Guardians Name: _____Relationship to child: _____

Address: _____ City:_____ State: _____ ZIP: _____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone:(____)_____

Occupation (If applicable): _____

Primary Insurance: _____Policy # _____Grp #_____

Secondary Insurance: _____ Policy # _____Grp # _____

How may we help you today? _____

_____

Has your child ever had a hearing test before? ____ YES ____ NO
If yes, when and where? _____

FAMILY HISTORY

Parents related before marriage: __YES__NO Family history of thyroid problems: __YES__ NO

Family history of hearing loss: __YES__NO History of stillbirths/miscarriages: __YES__NO

History of progressive blindness: __YES__NO Family history of kidney disease: __YES__NO

Mother worked outside home during pregnancy: __YES__NO If yes, where?_____

Father worked outside home during pregnancy: __YES__NO If yes, where?_____

MATERNAL FACTORS

Medications taken during pregnancy (including antibiotics): ___YES ___NO
If yes, specify:_____

Exposure to chemicals during pregnancy: ___YES ___NO
If yes, specify:_____

Exposure to radiation/chemotherapy during pregnancy: ___YES ___NO
If yes, specify:_____

Amniocentesis performed during pregnancy: ___YES ___NO

Rh immunoglobulin given; Rh or ABO incompatible ___YES ___NO

Illness during pregnancy: ___YES ___NO
If yes, specify:_____

Any paternal illnesses during pregnancy: ___YES ___NO
If yes, specify:_____

During pregnancy was mother exposed to: ___Chickenpox ___Measles ___Mumps ___German Measles

During pregnancy was mother diagnosed with: __Syphyllis __Herpes __Influenza __Cytomegalovirus
__HIV/AIDS __Toxoplasmosis __Anemia __Diabetes

Child Case History

DELIVERY AND LABOR FACTORS

Full-term pregnancy: ___YES ___NO If no, how many weeks early:_____

Labor was induced: ___YES ___NO Labor was: ___>3Hrs ___<24 Hrs

Premature membrane rupture: ___YES ___NO Bleeding: ___YES ___NO

Forceps delivery: ___YES ___NO Cesarean section (C-section):___YES ___NO

Other unusual events: _____

NEWBORN FACTORS

Birth weight less than 5lbs ___YES ___NO APGAR score low at birth ___YES ___NO

Placed in intensive care: ___YES ___NO Breathing problems at birth ___YES ___NO

Oxygen given at birth ___YES ___NO Bilirubin >15mg/100ml ___YES ___NO

Congenital rubella ___YES ___NO Defects of ear, nose, throat ___YES ___NO

Congenital heart disease ___YES ___NO Exposure to chemicals ___YES ___NO

Paralysis at birth ___YES ___NO Seizures at birth ___YES ___NO

Septicemia ___YES ___NO

Drugs given(inc. antibiotics) ___YES ___NO If yes, specify: _____

INFANT/CHILDHOOD FACTORS

Eye problems ___YES ___NO If yes, specify: _____

Balance/gait/dizziness problems ___YES ___NO Cerebral palsy ___YES ___NO

Seizures ___YES ___NO Seizures ___YES ___NO

Head/skull injury ___YES ___NO If yes, specify: _____

CHILD EVER HOSPITABLIZED FOR/DIAGNOSED WITH/TREATED FOR:

Meningitis ___YES ___NO Encephalitis ___YES ___NO Measles ___YES ___NO

Diabetes ___YES ___NO Influenza ___YES ___NO Cytomegalovirus(CMV) ___YES ___NO

Chickenpox ___YES ___NO Septicemia ___YES ___NO Sickle Cell ___YES ___NO

Rubella ___YES ___NO

HISTORY OF EAR PROBLEMS

Ear infections: ___NONE ___LEFT ___RIGHT ___BOTH
If yes, specify: _____

Tube placement: ___NONE ___LEFT ___RIGHT ___BOTH
If yes, specify: _____

HEARING ASSOCIATES OF NORTHERN VIRGINIA
6862 Elm St. #120 McLean, VA 22101

Patient Acknowledgement and Consent Form

Acknowledgement of Notification

The educational material entitled "Notice of Privacy Practices" provides information about how the Hearing Associates of Northern Virginia may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post the change in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, or health care operations. We are not required to agree to your restrictions: but if we do we are bound by our agreement with you.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure, including the following procedures; We educate our staff to keep information confidential; we discard protected information in appropriate containers or shred it; we require your written authorization prior to disclosing information to sources not identified in our privacy practices; you may revoke your written authorization at any time by sending us a written request.

By signing below, you acknowledge that our Privacy Policy has been available to you.

_____
___
Patient's Signature Today's Day

Consent for us and Disclosure of Information

By signing below, you consent to the use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare or any other insurance carrier benefits be made on my behalf to the Hearing Associates or Northern Virginia for any services and/or products furnished to me by the health care specialist or supplier. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to provide all referral as required by my insurance carriers. All co-pays must be paid at time of services in accordance with the contracted insurance carrier agreements. All non-covered services and/or products must be paid for all the time the service is rendered or the product is dispensed.

_____
___
Patient Signature Today's Date