7200 Cameron Park Drive
Fort Smith, AR 72903
Phone: 479-785-3277
Fax: 479-785-3278

Audiologists
Kelley Linton, Au.D.
Trace Cash, Au.D.
Lori Boyd, Au.D.
Kailey Thompson, Au.D.

PEDIATRIC PATIENT INFORMATION

Last Name ___________________________ First Name _______________________ M.I. ______ Date of Birth ____/____/______

Age ____ Sex ___ Race __________ Ethnicity ____Hispanic ___Not Hispanic Preferred Language_________________________

Address ____ Apt # ______ City __________________ State _________ Zip ________

Primary Phone ________________________ Alternate Phone _________________________

PARENT/GUARANTOR INFORMATION

Name__________________________________ Relationship to Patient _____________________ Date of Birth_____/____/_____

Address______________________________________City_____________________ State __________________Zip ___________

Home Phone________________________ Cell Phone_______________________ Work Phone ____________________________

How may our office best contact you? (Check one) _____Home Phone _____Cell Phone _____Work Phone Preferred method of appointment reminder? _____Text _____Phone (circle: cell or home)

Email Address: ____Occupation____

Emergency Contact:______________________Relationship_________________Phone number:___________________________

INSURANCE INFORMATION

Primary Insurance Carrier _____________________________ Secondary Insurance Carrier ___________________________

ID# ______ ____ ID# ____

Group # ____ Group # ____

Subscriber Name ____________________________________ Subscriber Name ____________________________________

Subscriber Birth Date _________________________________ Subscriber Birth Date _______________________________

Relationship to Patient ________________________________ Relationship to Patient _______________________________

REFERRING PHYSICIAN

Referring Physician Name _______________________________ Practice Phone _____________________________________

Primary Care Physician _________________________________ Practice Phone _____________________________________

May we thank someone else (non-physician) for referring you to our office? ____

ALLERGY INFORMATION

Drug Allergies _____________________________________Environmental Allergies______________________________________

Are you allergic to latex? _____ Yes _____ No Are you allergic to medical tape? _____ Yes _____ No

SOCIAL HISTORY

Attend day care _____Yes _____No Pets in home _____Yes _____ No Cigarette Smoke exposure _____Yes ______No

Patient Name:____Date of Birth: ____________________

PATIENT REVIEW OF SYSTEMS

Do you frequently have or frequently experience: (Please check ALL that apply)

General	____**Healthy**	____ Prematurity	____Failure to thrive	____Fatigue
		____Fever	____Weight Gain	____Weight Loss
Review of System	____**None**	____Hyperactivity	____Attention deficit	____Anxiety
		____Depression		
Allergy/Immunologic	____**None**	____Reactions	____Itching	____Sneezing
		____Eye Irritation	____Immune Problems	____ Other: _________
Eyes	____**None**	____Strabismus	____Diminished visual acuity	
		____Discharge	____Other:_________________	
Ears, Nose, Throat & Mouth	____**None**	____ Bruxism (teeth grind)	____Nose Blocked	____Voice Changes
		____Pressure in ear	____ Difficulty Swallowing	
		____Nosebleed	____Ringing in ears	____Sinus Pain
		____Sore Throat	____Other:______________	
Endocrine	____**None**	____Hormone Problems	____Growth Disturbance	
		____Other:____________________________________		
Respiratory (Lungs)	____**None**	____Cough	____Shortness of Breath while Sitting	
		____Wheezing	____Shortness of Breath with Exertion	
Cardiovascular (Heart)	____**None**	____Heart Murmur	____Syncope	____Chest Pain
		____Cyanosis	____Irregular heart beat	____Other:___________
Gastrointestinal	____**None**	____GERD	____Constipation	____Diarrhea
		____Indigestion	____Nausea	____Vomiting
Hematologic/Lymph Nodes	____**None**	____Anemia	____Blood disorder	____Bleeding easily
		____Easy bruising		
Genitourinary	____**None**	____Urination at Night	____Kidney Problems	____Other:____________
Musculoskeletal	____**None**	____Fractures	____Bone disease	____Painful Joints
		____Weakness		
Integumentary	____**None**	____Dry Skin	____Eczema	____Itchy skin
		____Rash		
Neurological (Nerves)	____**None**	____Meningitis	____Head Injury	____Dizziness/Vertigo
		____Headache	____Seizures	
Psychiatric	____**None**	____Hyperactivity	____Anxiety	____Depression
		____Other:______________		

Patient Comments: ____
____

Patient Name: ____ Date of Birth: ___________________

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication____ Reason for Taking ________________________________

Medication____ Reason for Taking ________________________________

Medication____ Reason for Taking ________________________________

HEALTH HISTORY

What concerns are you here for today? ____

Do you currently have or frequently experience:

____Allergy Problems ____Birth Defects/Syndrome ____Immune Deficiency ____ Respiratory ____Asthma ____Bleeding Disorders
____Heart Problems ____ Speech/Language Delay ____Anesthesia Problems ____Developmental Disorders ____ Neurological Problems
____Other:____

Birth History Was your child born premature ____Yes ____No Gestational age at delivery ___________________
Complications of Prematurity ____
Prenatal Complications _______________________Current Weight __________Immunizations up to date ____Yes ____No
Did child pass newborn hearing screen ____Yes ____No ____Unsure Any current therapy (PT/OT/Speech)_______________

Have you undergone any of the following surgeries?

Tonsillectomy Date: ____________________ Adenoidectomy Date:______________________
Ear Surgery Date: ____________________ Thyroid Surgery Date:______________________
Ear Tubes Date: ____________________ Nasal/Sinus Surgery Date:______________________
Other____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S= Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM=Paternal Grandmother, PGF=Paternal Grandfather

____Alcoholism	____Cancer	____Heart Attack	____Lung Problem
____Anemia	____Chronic Ear Infections	____Heart Failure	____Mental Illness
____Arthritis	____Depression	____Hepatitis	____Reflux
____Atrial Fibrillation	____Diabetes	____High Blood Pressure	____ Sleep Apnea
____Asthma	____Emphysema	____High Cholesterol	____ Stroke
____Birth Defects	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Bladder Disease	____Glaucoma	____Kidney Disease	____Tuberculosis
____Bleeding Disorder	____Headaches	____Liver Problem	____Weight Loss/Gain

Other: ____

I consent to be examined by the Audiologists/Providers at Center for Hearing and Balance at each visit and request that payment of authorized benefits be made to Center for Hearing and Balance on my behalf, for any services provided by me or my dependent. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance carrier, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I understand that I am financially responsible for any charges incurred regardless of any problems, which may arise with my insurance carrier. All charges, whether or not paid by my insurance carrier will apply when needed. I authorize the use of this signature on all insurance claims submissions and a copy of this authorization to be used in place of its original.

Signature of Patient/Legal Guardian ____ **Date:** _________________________