Center for Audiology

Pediatric Information and History Form

Please complete all information. If not applicable, write N/A. Present all insurance cards to the receptionist.

PLEASE PRINT

Reason for visit? ______________________________

How did you hear about our office or Referring Provider? ______________________________

Who is accompanying the patient today? ______________________ ______________________

Name | Relationship to Patient

______________________, ______________________, ____ ______________ ______________

Last Name | First Name | Mi. | Date of Birth | Social Security #

______________________ ______________________ ______ ______

Address | City | State | Zip

(_______)______________________ (_______)______________________ Circle Gender: Male Female

Contact Phone # | Alternate Phone #

______________________ ______________ ______________

Parent (or Legal Guardian) Name | Date of Birth | Social Security #

______________________ ______________________

Email Address | Pediatrician Name

____

Emergency Contact Name, Relationship, & Phone Number (Not living in your home)

Did your child have a Newborn Hearing Screening? Yes No Unknown **Result:**______________________

Birth Hospital? ______________________________

Does your child receive speech services? Yes No **Facility:**______________________

Please list or provide a list of current medications: ______________________________

Check all that apply to the patient:

- ☐ Family Hearing Loss
- ☐ Prematurity
- ☐ Low Birth Weight
- ☐ Infection at Birth
- ☐ NICU Stay
- ☐ Cleft Lip or Palate
- ☐ Frequent Ear Infections
- ☐ Trauma to the Head
- ☐ Ear Surgery
- ☐ Other Developmental Delay
- ☐ Speech or Language Delay
- ☐ Cancer
- ☐ Measles, Mumps, or Meningitis
- ☐ Diagnosis of Genetic Disorder
- ☐ Other: ______________________