Parker
HEARING INSTITUTE

CHILD HEARING PATIENT INFORMATION

PLEASE PRINT

LAST_____FIRST_____ MI_____

D.O.B. _____ AGE _____ SEX □ M □ F

PARENT OR RESPONSIBLE PARTY INFORMATION

Name _____□ Father □ Mother □Other_____

Address _____City _____ State _____Zip_____

Best Contact # ( ) _____ Social Security # _____ DOB_____

Occupation _____

Email address_____ May we send you information □ YES □ NO

Name_____ □ Father □ Mother □ Other_____

Address _____ City_____ State_____ Zip _____

Best Contact # ( ) _____ Social Security# _____DOB_____

Occupation _____

HOW DID YOU HEAR ABOUT US?

□Mail □Newspaper□ Promotional Call □Yellow Pages □Website □Internet

□Other _____

□Referred by Friend/Family_____

□Referred by Physician _____ Phone#_____

FINANCIAL INFORMATION □ Cash □ Insurance □

Insurance Name_____ ID #_____ Grp#_____

Primary Subscriber Name _____

Secondary Insurance _____ID#_____Grp#_____

Primary Subscriber Name_____

ASSIGMENT & RELEASE

I hereby assign my insurance benefits to be paid directly to Parker Hearing Institute/William Lee Parker, PhD & Associates Inc. I authorize the release of information required to process this claim. I acknowledge that I bear ultimate financial responsibility for all services rendered regardless of insurance disposition.

Signed _____ Date_____
(Parent or guardian if patient is a minor)

Print_____

PLEASE FILL OUT THE REVERSE SIDE OF THIS SHEET

CHILD HEARING: CASE HISTORY

(Circle YES or NO for the following questions or answer accordingly)

1. Do you feel that your child has a hearing problem? YES NO
2. Does your child have a history of repeated ear infections? YES NO
3. Has your child had ear surgery? (If yes, when? _____) YES NO
4. Are there any other medical problems? (If yes, explain) YES NO

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5. Do you feel that your child has a speech problem? YES NO
6. Does your child currently wear a hearing aid(s)? YES NO
7. Do you use sign language with your child? YES NO
8. How well does your child communicate with you? GOOD FAIR POOR
9. Has your child been exposed to loud noise (e.g. firecrackers, guns, loud rock music, motorcycles)? YES NO
10. Is there a history of hearing loss in your family (parents, siblings, grandparents, aunts, uncles, etc.)? YES NO
11. Is your child learning disabled? (If yes, please explain) YES NO

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12. Were there any unusual birth circumstances? (If yes, please explain) YES NO

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13. Does your child have coordination problems? (If yes, please explain) YES NO

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14. Do you have any concerns or questions? YES NO

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