ADVANCED AUDIOLOGY OF NY

New Child Intake Form

Patient Information

Child's Name: | Date of Birth:

Parent/Guardian Names:

Mailing Address:

City: | State: | Zip:

Home Number: | Parent/Guardian Cell Number:

Parent/Guardian's Work Number:

Parent/Guardian's Email Address:

How did you hear about us?

Emergency Contact:

Name:

Relationship: | Phone Number:

Medical Information:

Physician Name: | Phone Number:

Address:

City: | State: | Zip:

Insurance Information:

Primary: | Secondary: | Insured Name:

Marital Status: (For Insurance Purposes) | Insured DOB (if not self):

Payment:

Guarantor (Person Responsible for Payment, if other than Patient):

Date of Birth: | Social Security Number: | Phone Number:

Address:

City: | State: | Zip:

Employer: | Address:

City: | State: | Zip:

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Insurance Release:
I, UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH_____ AND ASSIGN DIRECTLY TO Advanced Audiology of NY ALL OF MY INSURANCE BENEFITS , IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE Advanced Audiology of NY, TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Authorized Signature:		Date	

Medical Release: I authorize Advanced Audiology of NY to forward any records and test results to my child's physician.

Parent/Guardian Signature:		Date	

Acknowledgement of Financial Responsibilily: I acknowledge and accept final responsibility for payment of all charges for services rendered.

Parent/Guardian Signature:		Date	

Does your child have any medical concerns?	☐ Yes ☐ No	Conversations?	☐ Yes ☐ No
Is there a family history of ear/hearing problems?	☐ Yes ☐ No	Listening in noise?	☐ Yes ☐ No
Were there problems during pregnancy/delivery?	☐ Yes ☐ No	Are there concerns about your child's speech?	☐ Yes ☐ No
Did your child fail the hearing screening at birth?	☐ Yes ☐ No	Does your child have frequent/severe colds?	☐ Yes ☐ No
Are there concerns about overall development?	☐ Yes ☐ No	Has your child had ear infections or fluid build up?	☐ Yes ☐ No
Has your child been hospitalized?	☐ Yes ☐ No	If so, approximately how many times?	_____
Has your child had Meningitis?	☐ Yes ☐ No	Has your child had surgery for ear problems?	☐ Yes ☐ No
Has your child had a head injury?	☐ Yes ☐ No	If so, what was done and when?	_____
Does your child have allergies?	☐ Yes ☐ No	Has your child had their tonsils/adenoids removed?	☐ Yes ☐ No
Are there any allergies in the family?	☐ Yes ☐ No	Is your child on an IEP at school?	☐ Yes ☐ No
Are there concerns about your child's hearing?	☐ Yes ☐ No	If so, who is the case manager?	_____
Are there concerns in how your child responds to:		Are there any concerns in school?	☐ Yes ☐ No
Their name?	☐ Yes ☐ No	Do you want your child to hear and understand better?	☐ Yes ☐ No
The T.V.?	☐ Yes ☐ No		

IN THE ORDER OF IMPORTANCE FROM 1-6 Please indicate what's most important to help us meet your child's hearing needs: (#1 is the most important and #6 is the least important)

☐ Understanding Speech Better	☐ Function in Noise	☐ Comfort
☐ Inconspicuous Appearance	☐ Cost	☐ Service

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Notice of HIPAA Privacy Practices

A copy of this policy can be given to you upon request.

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices, and consent to share my health information for payment and treatment purposes. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

Patient/Personal Representative Signature:		Date	
Representative's Relationship to Patient:		Date	

- ☐ Patient unable to sign
- ☐ Patient refuses to sign

Employee Signature:		Date	