Bloomington-Normal Audiology
Pediatric Registration Form

- ○ New patient registration – Date: _____
- ○ Updated information – Date: _____

Patient Name: _____ **Nickname:** _____

Date of Birth: _____ **Gender:** ○Male ○Female

Address: _____

		May we Contact?	**Preferred?**	**Messages?**
Mother's E-mail Address:	_____	☐	☐	
Father's E-mail Address:	_____	☐	☐	
Home Phone:	_____	☐	☐	☐
Mother's Work Phone:	_____	☐	☐	☐
Father's Work Phone:	_____	☐	☐	☐
Mother's Cell Phone:	_____	☐	☐	☐
Father's Cell Phone:	_____	☐	☐	☐

Spoken Language: ○English ○Spanish ○Other

Mother's Employer: _____ ○Part-Time ○Full-Time

Occupation: _____

Father's Employer: _____ ○Part-Time ○Full-Time

Occupation: _____

Primary Care Physician: _____ **Phone #:** _____

Other Physician/Specialist: _____ **Phone #:** _____

Responsible Party/Name of Insured: _____

DOB of Responsible Party/Insured: _____ **Address, if different:** _____

City, State, Zip: _____

We will make a copy of the front and back of your insurance card/s.

Current Medications (Please indicate drug name, how often it is taken, its dosage, and how it is taken):

_____

_____

_____

We will make a copy of the medication list.

Name of Person Answering History & Relationship: _____

Reason for Appointment/Concerns: _____

PRENATAL & BIRTH HISTORY:

Was the child adopted? ○ *Yes* ○ *No* **If yes, child's age at adoption:** _____

Unusual conditions or problems during pregnancy? ○ *Yes* ○ *No* **If yes, explain:** _____

Drugs or medications during pregnancy? ○ *Yes* ○ *No* **If yes, explain:** _____

Was the labor/birth…?: ☐ *Spontaneous* ☐ *Induced* ☐ *Planned C-Section* ☐ *Unplanned C-Section* **Complications?:** ○ *Yes* ○ *No*

Child's birth weight: _____ **Full term** ○ *Yes* ○ *No* **If no, how early:** _____

APGAR score: _____ **Time in nursery:** _____ **Hearing Screening:** ○ *Pass* ○ *Refer*

Were there any health problems during the first 2 weeks of life:

☐ **Autoimmune**	☐ **Jaundice**	☐ **NICU admission**	☐ **Hemorrhage**
☐ **Convulsions**	☐ **Incubator/Isolette**	☐ **Oxygen required**	☐ **Feeding Difficulty**
☐ **Difficulty breathing**	☐ **IV fluids/medications**	☐ **Transfusions**	

MEDICAL HISTORY:

Current general medical condition: ○ *Poor* ○ *Fair* ○ *Good* ○ *Excellent*

Major illnesses or hospitalization (other than at birth)? ○ *Yes* ○ *No* **If yes, explain:** _____

Has your child experienced or exhibited:

☐ **Chicken Pox**	☐ **Ear Pain**	☐ **Measles/Mumps**	☐ **Sensitivity to Sound**
☐ **Dizziness**	☐ **Frequent Colds**	☐ **Pneumonia**	☐ **Tonsillitis**
☐ **Ear Infections**	☐ **Head Injury**	☐ **Seizures**	☐ **Tubes in Ears**

Allergies? ○ *Yes* ○ *No* **If yes:** ○ *Suspected* ○ *Diagnosed* ○ *Treated* **If yes, list:** _____

Family History of Hearing Loss? ○ *Yes* ○ *No* ***Who & age of onset?*** _____

At what age (in months) did your child?

_____ **Use First Words** _____ **Use Sentences** _____ **Sit Alone** _____ **Walk Alone**

Were there any interruptions to normal development? ○ *Yes* ○ *No* **If yes, explain:** _____

ACADEMICS:

School: _____ **Grade:** _____ **Teacher:** _____

Has the child ever failed or been held back? ○ *Yes* ○ *No* **If yes, explain:** _____

Does the child receive services from any additional therapists or medical providers?: ○ *Yes* ○ *No*

If yes, describe: _____

_____ By initialing this section and signing below, I hereby acknowledge that I have read Bloomington-Normal Audiology Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.

_____ By initialing this section and signing below, I authorize Bloomington-Normal Audiology to send me educational and/or marketing information on the products and services offered by Bloomington-Normal Audiology.

_____ By initialing this section and signing below, I agree to accept Bloomington-Normal Audiology's Financial Policies and, as a result, accept the financial responsibility for all charges for services rendered to me and are not covered by my insurance plan. Payment in full is due on the date of service.

Signature of Patient or Guarantor: _____ **Date:** _____