bloomington normal audiology
Hear for you.

Pediatric Registration Form

○ New Patient Registration - Date: _____
○ Updated Information - Date: _____

Patient Name: _____ **Nickname:** _____
Date of Birth: _____ **Gender:** ○ Male ○ Female
Address: _____

Contact Information		May We Contact?	Preferred?	Messages?
Mother's Email Address:	_____	☐	☐	—
Mother's Cell Phone:	_____	☐	☐	☐
Mother's Work Phone:	_____	☐	☐	☐
Father's Email Address:	_____	☐	☐	—
Father's Cell Phone:	_____	☐	☐	☐
Father's Work Phone:	_____	☐	☐	☐
Home 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
- ☐ Convulsions
- ☐ Difficulty breathing
- ☐ Jaundice
- ☐ Incubator/Isolette
- ☐ IV fluids/medications
- ☐ NICU admission
- ☐ Oxygen required
- ☐ Transfusions
- ☐ Hemorrhage
- ☐ Feeding Difficulty

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
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Ear Pain
- ☐ Frequent Colds
- ☐ Head Injury
- ☐ Measles/Mumps
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sensitivity to Sound
- ☐ Tonsillitis
- ☐ 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:** _____