PEDIATRIC PATIENT MEDICAL HISTORY

Child's Name:______________________________ Today's Date:________________________

Age: ________ Date of Birth:__________________ Weight: __________(lbs)

Pediatrian:______________________________ Referring Doctor:________________________

Allergies to Medication: Yes or No If yes, please list____________________________________

Current Medications:____

Reason for child's visit:____

Duration of problem: # of days_______ weeks_______ months________ years__________

Was your child born full term? Yes or No (please circle)

Did your child pass their hearing screening at birth? Yes or No (please circle) Wears Hearing Aids? Yes or No

Was your child born with a birth defect? Yes or No (please circle) NICU stay after birth? Yes or No

SURGICAL HISTORY

List all surgeries by date and complications (if any):

____

____

____

ADDITIONAL INFORMATION

Please list any recent hearing tests, blood work, x-rays, CT scans, MRIs, swallowing studies, audiograms or important information that we need to know for your visit today and location where testing was done:

____

____

____

Does your child have or are you concerned that your child may have any of the following (please circle) If yes, please explain:

Hearing LossSpeech ProblemsHoarseness StutteringAnxiety

ADD/ADHDAuditory Processing Disorder Autism / Asperger'sBipolar

Cognitive DeficitsDyslexiaLearning DisabilitySensory Problems

____

____

____

Does your child or did your child receive any of the following services? If yes, please list where.

Speech Therapy: Yes or No ____

Occupational Therapy: Yes or No____

Physical Therapy: Yes or No____

Vision Therapy: Yes or No____

Enrolled in Early Steps? Yes or No____

IEP / 504 Plan at school? Yes or No____

FAMILY HISTORY

Do any of your close relatives have any of these conditions?
Bleeding Disorders?_______ Reactions to anesthesia?_______ Drug Reactions?_______
Fever with anesthesia?_______ Hereditary Disease?_______ Hearing loss?_________
Speech Problems?_________________
If yes to any of the above, please
explain:____

____

____

PATIENT REGISTRATION FORM

Patient Name:____

Local Address:____

City:________________________________State:_______________________Zip Code:__________

Home #:______________________Cell #:__________________________ Work #:_________________

Please Circle: Male / Female Age:_______ Birthdate:____________Soc Sec #:____-____-_____

Parent's Email address :____

Pharmacy:_____________________________________ Pharmacy Ph #:_________________________

Out of State Address:______________________________ City:______________________________

State:____________ Zip Code:________________ Out of State Ph #:_________________________

Mother's Name:______________________ Date of Birth:___________ S.S.#:___________________
Father's Name:______________________ Date of Birth:___________ S.S.#:___________________

INSURANCE INFORMATION

Primary Policy Holder's Name:____
Primary Policy Holder's Date of Birth:__________ Primary Policy Holder's S.S.#_______________

Secondary Policy Holder's Name:____
Secondary Policy Holder's Date of Birth:_______ Secondary Policy Holder's S.S.#_____________

Signature of Patient:___________________________________ Date:_________________________
Guardian's Signature (if minor)___________________________ Date:_________________________
Guardian's Name (please print):____
Relationship to Patient:____

Shea ENT Clinic and Physician's Hearing Clinic

HIPAA - Patient Consent of Information

Shea ENT Clinic & Physician's Hearing Clinic, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Shea ENT Clinic and Physician's Hearing Clinic from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Shea ENT Clinic and Physician's Hearing Clinic physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Shea ENT Clinic and Physician's Hearing Clinic physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message
_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with________________________relationship______________
_____ with________________________relationship______________

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

______________________________	_______________
Patient's Name (Please Print)	Date of Birth
______________________________	_______________
Patient's Signature	Date
______________________________	_______________
Witness	Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Shea ENT & PHC Practice.

_____I have declined a copy of Shea ENT & PHC Notice of Privacy Practice.

______________________________	_______________
Patient's Signature	Date