EAR-Central, PLLC

PEDIATRIC PATIENT INTAKE FORM

Welcome to the EAR-Central, PLLC, the practice of Michael O. Webb, Neuro-Audiologist and Specialist in Auditory Processing Disorders (CAPD)—diagnosis and treatment. We know filling out forms can be tedious, but to maximize this experience, help us to best treat your child by filling out the requested information (<u>both front & back sides, please</u>) as completely as possible! It will be worth it! Thanks!

Who referred you to us? _____

PERSONAL INFORMATION:

For Office Use:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
STREET CITY STATE ZIP

BIRTHDATE _____/_____/_____ AGE_____ MALE_____ FEMALE_____

SCHOOL ATTENDED _____ CURRENT GRADE _____ IEP: ☐ YES ☐ NO

NAME OF PARENT/ RESPONSIBLE PARTY_____

EMAIL ADDRESS OF RESPONSIBLE PARTY _____

RESPONSIBLE PARTY ADDRESS (IF DIFFERENT THAN PATIENT'S):

_____
STREET CITY STATE ZIP

TELEPHONE: (HOME) _____ (CELL) _____

(WORK)_____ **Please indicate preferred phone: ☐ Home ☐ Cell ☐ Work**

REASON FOR THIS VISIT: (Check All That Apply)

- ☐ Parent/Guardian Concern
- ☐ Pediatrician Concern
- ☐ Referred by Speech/Language or O.T. Specialist
- ☐ School Nurse or Special Education Referral
- ☐ Listening problems, but normal hearing tests
- ☐ Poor Educational Performance
- ☐ Referred by General Audiologist
- ☐ Part of a Diagnostic Process
- ☐ Referred by Neuropsychologist
- ☐ History of Ear Infections (P.E. tubes)

(<u>OVER, Please</u>: Complete <u>BOTH</u> sides of this form)

RISK FACTORS FOR POSSIBLE CENTRAL AUDITORY PROCESSING DEFICITS (CAPD) AND / OR PERIPHERAL HEARING LOSS

(Check All That Apply)

☐ Family history of permanent childhood hearing loss ☐ Family History of Auditory Processing Disorder **(CAPD)**
☐ Facial or other anatomical features/ other findings associated with a genetic syndrome known to include a risk of sensorineural and/or or conductive hearing loss—as well as possible neuro-developmental delays/deficits.
☐ Pre- or Postnatal infections associated with developmental problems, (e.g., bacterial meningitis, CMV, STDs; etc.)
☐ Parent(s) or sibling(s) with history of educational difficulty (e.g., reading, spelling, memory, math, organization.)
☐ Neonatal indicators – ☐ Prematurity ☐ NICU stay ☐ Jaundice or Rh incompatibility (hyperbilirubinemia), ☐ Low birthweight ☐Failed newborn hearing screening
☐ Head Trauma ☐ Concussion(s) ☐Seizure(s) ☐ Headaches/ Migraines ☐ Bothered by Loud Sounds ☐ Tinnitus (Ringing) ☐ Dizziness/ Balance ☐ Poor Coordination/ Clumsy ☐ Poor Musical Aptitude ☐ Difficulty learning foreign language ☐ Flat affect in speech ☐ Difficulty "getting" subtle humor or sarcasm ☐ Sleep apnea ☐ Poor auditory memory ☐ Poor vision/eye tracking ☐ Sensory Processing/ Autism Spectrum
☐ Therapy or other intervention for speech, language, reading/math (educational) and/or other developmental delays
☐ Phonics/ Reading/ Spelling problems ☐ Math (especially Word Problems) ☐ Poor attention/ hearing in class ☐ Failure to finish tasks, tests in permitted time ☐ Stressed/ fatigued after school ☐ Repeated grade(s) ☐ Feelings of failure/ frustration ☐ Difficulty managing noise/ visual distractions ☐ Lip-reads/ needs visual cues
☐ Was diagnosed with ADD or ADHD ☐ Takes medication for AD(H)D ☐ Takes other behavioral medications
☐ Recurrent or persistent otitis media (middle-ear infections or fluid accumulation)—with or without P.E. tubes

PLEASE READ AND SIGN / INITIAL WHERE INDICATED BELOW.

Tricare Beneficiaries, please present military ID card to be copied for your patient file.

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial only <u>ONE</u>*** ➔

Send a copy to my physician X_____ (initial)

OR

DO NOT send a copy to my physician X_____ (initial)

<u>Privacy Practices Notice</u>: According to federal law (HIPAA), we are required to make available to you a copy of our Notice of Privacy Practices (NPP). Your signature below acknowledges you received ☐ --OR-- waived receipt ☐ of our NPP:

SIGNATURE X_____ **DATE X**_____

<u>Tricare Beneficiaries Only</u>: I hereby authorize EAR-Central, PLLC to furnish information to UHC/ Military and Veterans (Tricare) concerning my medical condition and treatment, and I hereby assign to EAR-Central, PLLC all payments for services rendered to my dependentf. I understand that I am responsible for payment of professional charges determined to be non-covered expenses by my Tricare coverage (and having been notified in writing in advance of provision of such services via a Tricare Advanced Beneficiary Notice [ABN]).

SIGNATURE X_____ **DATE X**_____