



Child Case History

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Gender: _____

Guardians Name: _____ Relationship to child: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone:(____) _____

Occupation (If applicable): _____

Primary Insurance: _____ Policy # _____ Grp # _____

Secondary Insurance: _____ Policy # _____ Grp # _____

How may we help you today? _____

Has your child ever had a hearing test before? ___ YES ___ NO
If yes, when and where? _____

FAMILY HISTORY

Parents related before marriage: ___ YES ___ NO Family history of thyroid problems: ___ YES ___ NO

Family history of hearing loss: ___ YES ___ NO History of stillbirths/miscarriages: ___ YES ___ NO

History of progressive blindness: ___ YES ___ NO Family history of kidney disease: ___ YES ___ NO

Mother worked outside home during pregnancy: ___ YES ___ NO If yes, where? _____

Father worked outside home during pregnancy: ___ YES ___ NO If yes, where? _____

MATERNAL FACTORS

Medications taken during pregnancy (including antibiotics): ___ YES ___ NO
If yes, specify: _____

Exposure to chemicals during pregnancy: ___ YES ___ NO
If yes, specify: _____

Exposure to radiation/chemotherapy during pregnancy: ___ YES ___ NO
If yes, specify: _____

Amniocentesis performed during pregnancy: ___ YES ___ NO

Rh immunoglobulin given; Rh or ABO incompatible ___ YES ___ NO

Illness during pregnancy: ___ YES ___ NO
If yes, specify: _____

Any paternal illnesses during pregnancy: ___ YES ___ NO
If yes, specify: _____

During pregnancy was mother exposed to: ___ Chickenpox ___ Measles ___ Mumps ___ German Measles

During pregnancy was mother diagnosed with: ___ Syphillis ___ Herpes ___ Influenza ___ Cytomegalovirus
___ HIV/AIDS ___ Toxoplasmosis ___ Anemia ___ Diabetes



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DELIVERY AND LABOR FACTORS

Full-term pregnancy: YES NO If no, how many weeks early: _____

Labor was induced: YES NO Labor was: >3Hrs <24 Hrs

Premature membrane rupture: YES NO Bleeding: YES NO

Forceps delivery: YES NO Cesarean section (C-section): YES NO

Other unusual events: _____

NEWBORN FACTORS

Birth weight less than 5lbs YES NO APGAR score low at birth YES NO

Placed in intensive care: YES NO Breathing problems at birth YES NO

Oxygen given at birth YES NO Bilirubin >15mg/100ml YES NO

Congenital rubella YES NO Defects of ear, nose, throat YES NO

Congenital heart disease YES NO Exposure to chemicals YES NO

Paralysis at birth YES NO Seizures at birth YES NO

Septicemia YES NO

Drugs given(inc. antibiotics) YES NO If yes, specify: _____

INFANT/CHILDHOOD FACTORS

Eye problems YES NO If yes, specify: _____

Balance/gait/dizziness problems YES NO Cerebral palsy YES NO

Seizures YES NO Seizures YES NO

Head/skull injury YES NO If yes, specify: _____

CHILD EVER HOSPITALIZED FOR/DIAGNOSED WITH/TREATED FOR:

Meningitis YES NO Encephalitis YES NO Measles YES NO

Diabetes YES NO Influenza YES NO Cytomegalovirus(CMV) YES NO

Chickenpox YES NO Septicemia YES NO Sickle Cell YES NO

Rubella YES NO

HISTORY OF EAR PROBLEMS

Ear infections: NONE LEFT RIGHT BOTH

If yes, specify: _____

Tube placement: NONE LEFT RIGHT BOTH

If yes, specify: _____

HEARING ASSOCIATES OF NORTHERN VIRGINIA
6862 Elm St. #120 McLean, VA 22101

Patient Acknowledgement and Consent Form
Acknowledgement of Notification

The educational material entitled "Notice of Privacy Practices" provides information about how the Hearing Associates of Northern Virginia may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post the change in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, or health care operations. We are not required to agree to your restrictions: but if we do we are bound by our agreement with you.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure, including the following procedures; We educate our staff to keep information confidential; we discard protected information in appropriate containers or shred it; we require your written authorization prior to disclosing information to sources not identified in our privacy practices; you may revoke your written authorization at any time by sending us a written request.

By signing below, you acknowledge that our Privacy Policy has been available to you.

Patient's Signature Today's Day

Consent for us and Disclosure of Information

By signing below, you consent to the use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare or any other insurance carrier benefits be made on my behalf to the Hearing Associates or Northern Virginia for any services and/or products furnished to me by the health care specialist or supplier. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to provide all referral as required by my insurance carriers. All co-pays must be paid at time of services in accordance with the contracted insurance carrier agreements. All non-covered services and/or products must be paid for all the time the service is rendered or the product is dispensed.

Patient Signature Today's Date

