



Patient Communication Consent

Name: _____ Birth Date: ___/___/___ Sex: Male Female Non-Binary
Phone: _____ Cell Phone: _____ Email: _____
Address: _____ City: _____ State: ___ Zip: _____
SSN: _____ Marital Status: Single Married Widowed Divorced
Referred by: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Instructions for Communication Preferences:

I authorize PrairieLand Audiology to contact the following people with my test results:

Myself Only

____ Home

____ Cell

OK to leave a message on answering machine? ____ Yes ____ No

Other Name: _____ Relationship: _____

Other Name: _____ Relationship: _____

Authorization to Treat:

I hereby authorize my insurance benefits to pay directly to PrairieLand Audiology, realizing I am responsible to pay non-covered services. I authorize the release of medical information to my insurance carrier.

Signature: _____ **Date:** _____

Pediatric Case History Form



Patient Name: _____ Age: _____ Date: _____

1. For what reason was this hearing test arranged?

2. Has your child ever had a hearing test before? Yes No

If so, when and where? _____

3. Do you have any concerns about your child's hearing? Yes No

4. Does your child seem to hear better on some days than other? Yes No

5. Does anyone in your family have problems with their hearing? Yes No

6. Were any of the following present after your child's birth or during the first two months?

- | | | |
|------------------------------------------------------|---------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Poor weight gain |
| <input type="checkbox"/> Stayed in hospital | <input type="checkbox"/> Was in incubator | <input type="checkbox"/> Infections at birth |
| <input type="checkbox"/> Failed newborn hearing test | <input type="checkbox"/> Physical deformities | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> High fever | <input type="checkbox"/> Jaundice/appeared yellow | |

7. Does your child turn toward sound? Yes No

8. Has your child had ear infections? Yes No If so, how many? _____

9. Has your child had tubes placed in the ear(s)? Yes No If so, which ear(s) _____