Good Sound Audiology, PLLC **Find us on the web at: www.GoodSoundAudiology.com**

IDENTIFYING AND BACKGROUND INFORMATION

Child's Name: _____ Today's Date: _____
First Last

Date of Birth: _____ Age: _____ Gender: Male □ Female□

Address: _____
Street

_____ _____ _____
City State Zip

Father: _____ DOB: _____

Address: _____ Phone#: _____

Place of Employment: _____ Phone#: _____

Mother: _____ DOB: _____

Address: _____ Phone#: _____

Place of Employment: _____ Phone#: _____

In case of emergency contact: _____ Relationship: _____ Phone#: _____

Person Completing Questionnaire: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID#: _____ Group#: _____ Phone#: _____

Primary Insured Name: _____ Date of Birth: _____

Secondary Insurance Company: _____

ID#: _____ Group#: _____ Phone#: _____

Secondary Insured Name: _____ Date of Birth: _____

PHYSICIAN INFORMATION

Primary Physician Name: _____

Physician Address: _____ Phone#: _____

Would you like us to send a report to your doctor? Yes □ No □

REFERRAL INFORMATION

Reason for todays visit: _____

_____

How did you hear about our services?: _____

BIRTH AND PRENATAL HISTORY

Were there any complications during pregnancy or at birth? _____

_____

List drugs/medication taken during pregnancy: _____

MEDICAL INFORMATION

Please list any medications the child is currently taking: _____

_____

Check if the child has ever had the following:

- ❑ Ear Infection
- ❑ Ear Pain
- ❑ Head Injury
- ❑ Major Medical Problems (i.e. heart, lung, physical disabilities)
  Please explain: _____
- ☐ Ventilation tubes in the eardrum
- ☐ Ringing in ears
- ☐ Allergies
- ☐ Excessive ear wax
- ☐ Meningitis
- ☐ Asthma
- ☐ Seizures
- ☐ Dizziness
- ☐ High fever

Overnight stays and/or surgeries? Yes ☐ No ☐ If "yes", list date and reason: _____

_____

DEVELOPMENTAL HISTORY

Do you have any concerns with your child's development? Yes ☐ No ☐ If "yes", list date and reason: _____

_____

SPEECH AND LANGUAGE DEVELOPMENT

Are you concerned about your child's speech and language development? Yes ☐ No ☐ If "yes", explain: _____

_____

HEARING HISTORY

Did child pass the newborn hearing screening? Yes ☐ No ☐ If "no", explain: _____

_____

Check all that apply:

- ☐ The child has trouble hearing
- ☐ The child needs to hear instructions several times
- ☐ It helps the child when people speak loudly
- ☐ TV/Radio excessively loud
- ☐ There are sounds that make child uncomfortable
- ☐ The child "tunes in and out" of listening situations
- ☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school

Are you concerned about your child's hearing? Yes ☐ No ☐

If "yes", explain: _____

FAMILY HEARING HISTORY

Is there a family history of hearing loss? Yes ☐ No ☐. If "yes", explain who: _____

_____

Is there any other information you want the Audiologist to know?

_____

_____

I authorize the release of any pertinent medical information or test results to my childs primary physician and/or insurance company

_____

Parent/ Guardian Signature Date

I have been informed that the FDA recommends a medical evaluation of my childs ears by a medical doctor such as an ENT prior to the purchase of hearing aids.

_____

Parent/ Guardian Signature Date

Our Mission:

Good Sound Audiology understands the significant emotional and physical impact that hearing loss can have on one's life. We place strong emphasis on providing quality care that addresses both the physical and emotional concerns of our patients. We strive to provide individualized care in a warm and caring environment. Our goal is to assist each patient in finding solutions to their hearing health concerns.

Thank you for choosing Good Sound Audiology