PEDIATRIC PATIENT MEDICAL HISTORY

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

Age: _____ Date of Birth:_____ Height:_____ Weight: _____(lbs)

Pediatrician:_____ Referring Doctor(if different than Primary Dr. :_____

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) Weight at Birth:_____

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):

_____
_____
_____

FAMILY HISTORY

Do any of your close relatives have any of these conditions? If yes, please list relation:
(Includes: Father, Mother, Brother, Sister or others)
Bleeding Disorders?_____ Reactions to anesthesia?_____
Drug Reactions?_____ Fever with anesthesia?_____
Hereditary Disease?_____ Other:_____
_____

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 Loss **Speech Problems** **Hoarseness** **Stuttering** **Anxiety**

ADD/ADHD **Auditory Processing Disorder** **Autism / Asperger's** **Bipolar**

Cognitive Deficits **Dyslexia** **Learning** **Disability** **Sensory 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_____

Review of Symptoms: (Please CIRCLE all that applies)

Constitutional Symptoms: fevers chills weight changes night sweats

Cardiovascular: chest pain palpitations orthopnea edema PND claudication exercise intolerance

Respiratory: shortness of breath wheezing cough hemoptysis sputum production

Eyes: blurred vision pain redness specks double vision glaucoma glasses/contacts

Ears: hearing loss ringing pain drainage

Nose: stuffy discharge bleeding sinus pain itching

Throat: sore tongue sore throat hoarseness dry mouth

Gastrointestinal: abdominal pain nausea vomiting diarrhea blood in stool melena constipation heartburn Hx of ulcers appetite change dysphagia

Neurologic: dizzy fainting seizures tremors numbness tingling weakness memory loss headache

Endocrine: polyuria polydipsia heat/cold intolerance fatigue excessive sweating

Musculoskeletal: muscle pain joint pain joint instability

Genitourinary: dysuria frequency urgency hematuria nocturia incontinence penile/vaginal discharge

Skin: rash moles itching dryness lumps changing moles history skin cancer

Hemotologic/Lymphatic: swollen glands easy bruising clotting problems

Psychiatric: depression anxiety excess stress nervousness

Allergy/Immunology: hayfever drug allergies food allergy venom

Gynecologic: menses: regular irregular clots dysmenorrhea menorrhagia PMS
Age at menarch_____ Age at menopause_____ Children Alive_____ Children Deceased_____

*If nothing applies above, please sign here:_____

PATIENT REGISTRATION FORM

Patient Name:_____

Local Address:_____

City:_____State:_____Zip Code:_____

Home #:_____Cell #:_____ Work #:_____

Please Circle: Male / Female Age:_____ Birthdate:_____

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:_____
Father's Name:_____ Date of Birth:_____

INSURANCE INFORMATION

Primary Policy Holder's Name:_____
Primary Policy Holder's Date of Birth:_____ Relation to Patient:_____
SSN of Policy Holder:_____

Secondary Policy Holder's Name:_____
Secondary Policy Holder's Date of Birth:_____ Relation to Patient: _____
SSN of Policy Holder:_____

Guardian's Signature (of minor)_____ Date:_____
Guardian's Name (please print):_____
Relationship to Patient:_____

Shea ENT Clinic and Physician's Hearing Clinic

HIPAA –Patient Consent of Information and Financial Policy

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 the 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 phone # on a voicemail or with a live person answering the phone requesting the patient to return the phone call.

By completing the consent below, you are allowing Shea ENT Clinic and Physician's Hearing Clinic staff to leave a message on a machine/voicemail or with specified individuals. By signing, you are also consenting to the mailing, faxing or emailing of any results, requested by you to physicians of your choice.

I give my consent to Shea ENT Clinic and Physician's Hearing Clinic staff to leave a message regarding billing, appointments, surgery, lab results or other necessary information.

X	X	X
Print Patient Name	Signature of patient/parent	Date

People with Permission of whom to speak to with on my behalf

1)_____relation: _____ ph:_____

2)_____relation: _____ ph:_____

3)_____relation: _____ ph:_____

I have been provided a copy of Shea ENT and PHC Privacy Practice (circle) **YES / NO**

I have declined a copy of Shea ENT and PHC Privacy Practice (circle) **YES / NO**

FINANCIAL POLICY

I understand that all copays, deductibles or co-insurance dictated by my insurance are my responsibility at the time of service. I also acknowledge that any fees incurred by Shea ENT Clinic or Physician's Hearing Clinic while in the process of collecting on a bad check or through a collection agency are my responsibility. By signing below you acknowledge and agree to the financial responsibilities.

X	X	X
Print Patient Name	Signature of Patient	Date