Morris Audiology
119 E. Jefferson Street
Morris, IL 60450
(815) 941-4700

Child's Name: _____ Date: _____
Address:_____
City, State, Zip: _____
Home Phone:_____ Cell: _____Work #_____
Date of Birth:_____Age:_____Parent Name: _____
Parent Social Security #_____ Parent Employer_____
Child's Pediatrician: _____Phone_____

Insurance:_____ Employer:_____

Member# _____ Group# _____

Name of Policy Holder:_____ Policy Holder's DOB:_____

Reason for Appointment:_____

_____

How did you discover *Morris Audiology* services?

___Doctor	___Family	___Friend
___Newspaper	___Phone Book	___Lions
___Website	___Internet	___Other

The undersigned hereby authorizes Morris Audiology in the release of any information required in the processing of this claim and authorizes the insurance benefits to be paid directly to Morris Audiology. It is fully understood by the undersigned that all services are the undersigned financial responsibility. The undersigned also agrees should any unpaid balance go to a collection agency the undersigned is responsible for payment of all collection costs incurred, in an amount not to exceed fifty percent of the unpaid balance. In addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the court.

_____ _____
Signature **Date**

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BIRTH HISTORY:

List any drugs taken during pregnancy: _____

Was there any exposure to viral diseases during pregnancy? _____

Were there any unusual problems or difficulties at birth? _____

What was the child's birth weight? _____

Were there any health problems during the first two weeks of life? (**Circle all that apply**)

Autoimmune disease	Incubator or Isolette	NICU admission	Hemorrhage
Convulsions	Infection	Oxygen	Medication
Difficulty breathing	Intravenous fluids	Transfusions	Jaundice
Feeding difficulty	Other _____		

How long was the child in the nursery? _____

MEDICAL HISTORY:

General current medical condition: Poor Fair Good Excellent

Has the child had any major illnesses of hospitalizations other than at birth? Yes No

Please describe: _____

Has your child had: (**Circle all that apply**)

Ear Infections	Dizziness	Pulling at ears
Tubes in ears	Ringing in ears	Red ears
Head trauma	Pain/ discomfort in ears	Other _____

FAMILY HISTORY:

Please list any close relatives who have had hearing loss- excluding those due to trauma and infection.

Relation	Age at which hearing loss was identified
_____	_____
_____	_____
_____	_____

DEVELOPMENTAL HISTORY:

At what age (in months) did your child: _____Sit alone _____Walk alone

_____Use first words _____Use sentences

Privacy Acknowledgment

Patient Name: _____ Date of Birth: _____

I have read and or received this practice's Notice of Private Practices written in plain language. The Notice details the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make changes regarding all protected health information incident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

RELEASE OF INFORMATION:

I do hereby authorize **Morris Audiology** to release information to insurance carriers, other medical personnel and facilities, school systems, and/or other appropriate human service agencies with respect to the evaluation of: _____

Signature of parent: _____