***The* Hearing Doctor**
Brandy D. Vowell, Au.D.
521 E. Main Street, Jenks, OK 74037
(918) 779-7500 Fax: (918) 995-2333

Children/Teen Intake Information

Personal Information

Date of Intake:_____

Child's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Relationship: _____

Email:_____

Occupation:_____ Employer:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Name of Insurance Policy Holder:_____ Date of Birth:_____

Insurance Carrier:_____ Group Number: _____

Member ID:_____

Child's School_____Grade_____Handedness: ☐ Right ☐ Left

How were you referred to our office: Relative/Friend Insurance PCP/Pediatrician Online Radio Other:_____

Pediatrician's Information

Pediatrician:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Send Report? ☐ Yes ☐ No

Notice of Parental/Guarantor Responsibilities

You are responsible for all the fees associated with the care your child receives.
Payment is expected at the time of the service unless other arrangements have been made in advance.
It is your responsibility to understand your benefits and all obligations set forth by your insurance company.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available. Signing below authorizes The Hearing Doctor/Brandy D. Vowell, AuD to have assigned benefits of all charges submitted and to receive payment directly from the insurance company, and acknowledges responsibility for payment of bill in full by insured if insurance does not cover 100% in a timely fashion. Patient is responsible for entire medical bill regardless of amount paid/allowed by insurance. I am aware that services not covered by my insurance may include the following: case history review, diagnosis and recommendations, counseling, wax removals, vestibular testing, tinnitus exams, hearing aid checks, OSHA/workers compensation reviews, and hearing protection. I hereby authorize The Hearing Doctor/Brandy D. Vowell, AuD to release all information necessary to secure payment from my insurance and to provide my family physician with results regarding my appointment as The Hearing Doctor/Brandy D. Vowell, AuD deems necessary.

By signing below, I acknowledge that have read and understood the above information.

_____ _____

Print Patient Name Signature of Parent/Guardian

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Children/Teen Audiology History

What is the reason for today's visit?_____
Is this your child's first hearing exam? YES NO
If NO, When and where was he/she tested?_____

What were the results of the test?_____
Has your child ever been diagnosed with a hearing loss? YES NO
Have any of your child's prior doctors/specialists ever recommended any of the following:
Hearing Aids Sound Field System in School Assistive Hearing Devices Ear Surgery of Any Kind NONE

Does your child report noises (ringing/roaring/buzzing/crackling) in their ears? YES NO
Does your child report being dizzy or off balance? YES NO
Does your child report headaches or frequent fatigue? YES NO
Does your child engage in noisy recreational activities? YES NO
Band Loud Music Shooting/Hunting Power Tools/Equipment Other:_____

Birth History

Name of Hospital:_____

Prematurity: ☐ Yes ☐ No Gestational Age at Birth:_____weeks Birth Weight:

Jaundice: ☐ Yes ☐ No

Complications during pregnancy/delivery:_____

Medical attention following birth:_____

Blood transfusion	☐ Yes ☐ No
Medications	☐ Yes ☐ No
Cleft Palate	☐ Yes ☐ No
Craniofacial Anomalies	☐ Yes ☐ No
C-Section	☐ Yes ☐ No
Lack of Oxygen	☐ Yes ☐ No

Please explain if you answered yes to any of the above:

_____

Did your newborn spend any time in the NICU and if so why? _____

Did any family member smoke cigarettes in the household during pregnancy? ☐ Yes ☐ No

Did your child pass the newborn hearing screening? ☐ Yes ☐ No If no, which ear(s) failed? ☐ Right ☐ Left ☐ Both

Family History

Is your child adopted? ☐ Yes ☐ No

Did/Does any family member have any of the following diagnoses?

	Mother	Father	Sibling	
Seizure Disorder	☐	☐	☐	
ADHD/ADD	☐	☐	☐	
Autism/PDD/Asperger's	☐	☐	☐	
Learning Disability	☐	☐	☐	
Language Disorder	☐	☐	☐	
Articulation Disorder	☐	☐	☐	
Hearing Loss	☐	☐	☐	Age related? ☐ Yes ☐ No
Auditory Processing	☐	☐	☐	
Dyslexia	☐	☐	☐	

Developmental History

Did your child have delayed speech/language development? ☐ Yes ☐ No
Did your child have delayed motor development? ☐ Yes ☐ No
Did your child have sensory issues? ☐ Yes ☐ No
Did your child receive early intervention services? ☐ Yes ☐ No
If so:
☐ Speech therapy
☐ OT
☐ PT
☐ Sensory Integration
☐ Play Group

Hearing History

Does your child respond to sound consistently? ☐ Yes ☐ No
Do you feel you need to repeat things for your child in order to be understood? ☐ Yes ☐ No
Does your child say "what?" or "huh?" frequently? ☐ Yes ☐ No
Do you need to raise your voice in order for your child to respond? ☐ Yes ☐ No
Does your child like to sit close to the television, or does he/she turn up the volume? ☐ Yes ☐ No
Does your child appear to have difficulty understanding speech in background noise? ☐ Yes ☐ No
Has your child had a formal hearing test by an audiologist? ☐ Yes ☐ No
Did your child have any ear infections in the first 18 months of life? ☐ Yes ☐ No
If so, how many?_____
At what age did your child's first ear infection?_____
Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)? ☐ Yes ☐ No
Has your child ever received pressure equalizing (ventilating) tubes for chronic ear infections? ☐ Yes ☐ No
How many sets of tubes?_____ At what age?_____
Does your child have a frequent runny nose? ☐ Yes ☐ No
Does your child have frequent colds? ☐ Yes ☐ No
Does your child have allergies?

Medical History

Does your child present with any of the following medical conditions?
☐ Head trauma/injury
☐ Seizure disorders
☐ Visual problems
☐ Syndrome_____
☐ High Fevers/Serious Illness
☐ Hospitalizations/Surgeries
Other Diagnoses/Disorders: _____

Does your child interact well with others his/her own age? ☐ Yes ☐ No

Behavior problems? ☐ Yes ☐ No

Does your child currently take medication? ☐ Yes ☐ No

If so, please list on the back of this page or provide a copy for the chart.

Medication List

_____

Additional Comments/Observations/Concerns:

_____

_____