THE HEARING DOCTOR
BRANDY D. VOWELL, AU.D.

NEWBORN SCREENING INTAKE

521 E. MAIN STREET JENKS, OK 74037
(918) 779-7500 FAX: (918) 995-2333

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:_____

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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Birth History

Name of Hospital:_____

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

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:

_____

_____

Duration of labor:_____

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

Birth weight_____

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	☐	☐	☐
Auditory Processing	☐	☐	☐
Dyslexia	☐	☐	☐

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Medical History

Does your child present with any of the following medical conditions?

☐ Head trauma/injury
☐ Seizure disorders
☐ Visual problems
☐ Syndrome_____
☐ Hearing Loss
☐ High Fever

Does your child currently take medication? ☐ Yes ☐ No

List:

_____

Does your child currently receive any outpatient therapy services?

☐ Speech/Language
☐ OT
☐ PT
☐ SI
☐ Other:_____

Additional

Comments/Observations/Concerns:_____

_____

_____

_____

_____

_____

_____