



# Patient Registration Form

- ☐ New patient registration  
☐ Update of current patient demographic information

## Demographic Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Completion: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Birth Gender (*check one*): ☐ Male ☐ Female

Gender (*check one*): ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Non-Binary

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Primary Contact (*check one*): ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Appointment Reminders (*check all that apply*): ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

If child, please list the name of the custodial parents/guardians: \_\_\_\_\_

Marital Status (*check one*): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Name of Spouse/Partner, if applicable: \_\_\_\_\_

Current Employment Status (*check one*):

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Stay at Home Parent ☐ Student

Current Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Highest Level of Education Completed: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Spoken Language (*complete all that apply*): ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_

Race (*check one*): ☐ American-Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other: \_\_\_\_\_

Ethnicity (*check one, if applicable*): ☐ Hispanic ☐ Latino

## Emergency Contact Information

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## Physician Information

Referring Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Would you like Hearing Doctors of NJ to send a copy of your current and future test results and/or reports to

(please check all that apply; by checking the box and listing names below, you are authorizing Hearing Doctors of NJ to communicate with these entities regarding your healthcare and treatment):

☐ Referring Physician: \_\_\_\_\_

☐ Primary Care Physician (PCP): \_\_\_\_\_

☐ Other Physician, please specify: \_\_\_\_\_

☐ School, please specify: \_\_\_\_\_

☐ Family Member(s)/Guardian(s), please specify: \_\_\_\_\_

☐ Other: \_\_\_\_\_

☐ None (self-pay option only)

### How did you hear about Hearing Doctors of NJ? (Please check all that apply):

☐ Hearing Doctors of NJ Facebook Page

☐ Hearing Doctors of NJ Website

☐ Hearing Doctors of NJ Sign

☐ Health Fair Event

☐ Open House

☐ Internet/Search Engine, please specify which one:

\_\_\_\_\_

☐ Family Member/Friend, please provide full name so Hearing Doctors of NJ may thank him/her for the referral: \_\_\_\_\_

☐ Doctor, please specify:

\_\_\_\_\_

☐ Phone book, please specify which one:

\_\_\_\_\_

☐ Direct Mail Piece, please specify which one:

\_\_\_\_\_

☐ Newspaper, please specify which one:

\_\_\_\_\_

☐ Other:

\_\_\_\_\_

## Signature Information

\_\_\_\_\_ (*initial here*) By initialing this section and signing below, I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. The Notice provides information about how Hearing Doctors of NJ may use and disclose the medical information that is maintained about you. Hearing Doctors of NJ encourages you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

\_\_\_\_\_ (*initial here*) By initialing this section and signing below, I authorize Hearing Doctors of NJ to send me educational and/or marketing information on the products and services offered by Hearing Doctors of NJ. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

\_\_\_\_\_ (*initial here*) By initialing this section and signing below, I agree to accept the financial policies of Hearing Doctors of NJ. I understand that payment in-full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

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Signature of patient or custodial parent/guardian

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Date

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Printed name of patient or custodial parent/guardian

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Date



HEARING DOCTORS  
OF NEW JERSEY

## Office and Financial Policies

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Thank you for choosing Hearing Doctors of NJ for your hearing and balance healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Hearing Doctors of NJ is only an in network provider with Horizon NJ Health. We are an out of network provider with all other insurance plans.

Insurance coverage is an agreement between you and your insurance carrier. It is your responsibility to determine whether or not you have out-of-network benefits, if you require prior authorization or a referral prior to services being provided, or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Hearing Doctors of NJ cannot submit a claim to any insurance carrier we are out of network with. Upon payment in full for services rendered, you will receive a paid in full invoice that you can submit to your insurance carrier for reimbursement.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Hearing Doctors of NJ reserves the right to charge a \$50 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you, if time allows. Otherwise, we will need for you come back later in the day, if a later appointment is available, or reschedule to another date and time.

Payment in-full is due at the time the services are provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply.

Hearing Doctors of NJ accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover credit card. We also offers a third-party credit program through CareCredit and Healthi Plan. There will be a \$50 fee for all bounced or returned checks.

It is also the policy of Hearing Doctors of NJ that we may maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 90 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment, if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Hearing Doctors of NJ reserves the right, following 90 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

I understand if I have an unpaid balance to Hearing Doctors of NJ and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Hearing Doctors of NJ or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Hearing Doctors of NJ and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

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Signature of patient or personal representative

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Date



# Notice of Privacy Practices

**This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

## **ABOUT THIS NOTICE**

Hearing Doctors of NJ is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how Hearing Doctors of NJ may use and disclose your protected health information to carry out treatment, payment or audiologic/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and Hearing Doctors of NJ's duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health/condition and related audiologic/health care services. Hearing Doctors of NJ must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

## **HOW HEARING DOCTORS OF NJ MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following categories describe the different ways that Hearing Doctors of NJ may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

### **Treatment**

Hearing Doctors of NJ may use and disclose your protected health information to provide, coordinate, or manage your audiologic treatment and any related services. Hearing Doctors of NJ may also disclose your protected health information to other third party providers involved in your audiologic/health care. For example, your protected health information may be provided to a physician or other audiologic/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiologic/health care provider has the necessary information to diagnose or treat you.

### **Payment**

Hearing Doctors of NJ may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payers. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiologic/health care services Hearing Doctors of NJ recommends for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, Hearing Doctors of NJ may provide your health plan with medical information about the audiologic/health care services Hearing Doctors of NJ rendered to you for reimbursement purposes.

## **Audiological/Health Care Operations**

Hearing Doctors of NJ may use and disclose your protected health information for audiologic/health care operation purposes. These uses and disclosures are necessary to make sure that all patients receive quality care and for operation and management purposes. For example, Hearing Doctors of NJ may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of Hearing Doctors of NJ's team members in caring for you. Hearing Doctors of NJ also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

## **Treatment Communications**

Hearing Doctors of NJ may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which Hearing Doctors of NJ or a business associate may receive financial remuneration in exchange for making the communication, Hearing Doctors of NJ must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

## **Fundraising Activities**

Hearing Doctors of NJ may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Hearing Doctors of NJ. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039.

## **Others Involved in Your Healthcare**

Unless you object, Hearing Doctors of NJ may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Hearing Doctors of NJ may disclose such information, as necessary, if Hearing Doctors of NJ determines that it is in your best interest based on professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, Hearing Doctors of NJ may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. Hearing Doctors of NJ may also use and disclose protected health information to notify such persons of your location, general condition, or death. Hearing Doctors of NJ also may coordinate with disaster relief agencies to make this type of notification. Hearing Doctors of NJ also may use professional judgment and experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

## **Required by Law**

Hearing Doctors of NJ may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

## **Public Health**

Hearing Doctors of NJ may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Hearing Doctors of NJ may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

## **Business Associates**

Hearing Doctors of NJ may disclose your protected health information to business associates that perform functions on Hearing Doctors of NJ's behalf or provide Hearing Doctors of NJ with services if the information is necessary for such functions or services. To protect your health information, however, Hearing Doctors of NJ require the business associate to appropriately safeguard your information.

## **Communicable Diseases**

Hearing Doctors of NJ may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

## **Health Oversight**

Hearing Doctors of NJ may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the audiologic/health care system, government benefit programs, other government regulatory programs and civil rights laws.

## **Abuse or Neglect**

Hearing Doctors of NJ may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, Hearing Doctors of NJ may disclose your protected health information if Hearing Doctors of NJ believes that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

## **Food and Drug Administration**

Hearing Doctors of NJ may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

## **Legal Proceedings**

Hearing Doctors of NJ may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

## **Law Enforcement**

Hearing Doctors of NJ may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

## **Coroners, Funeral Directors, and Organ Donation**

Hearing Doctors of NJ may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. Hearing Doctors of NJ may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. Hearing Doctors of NJ may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

## **Research**

Hearing Doctors of NJ may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

## **Serious Threat to Health or Safety**

Consistent with applicable federal and state laws, Hearing Doctors of NJ may disclose your protected health information to prevent or lessen a serious threat to your health and safety, or to the health and safety of another person or the public.

## **Military Activity and National Security**

If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, Hearing Doctors of NJ may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

## **Workers' Compensation**

Hearing Doctors of NJ may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

## **For Data Breach Notification Purposes**

Hearing Doctors of NJ may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

## **Required Uses and Disclosures**

Under the law, Hearing Doctors of NJ must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

## **SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION**

The following uses and disclosures will be made only with your written authorization:

- Uses and disclosures of protected health information for marketing purposes for which Hearing Doctors of NJ or a business associate may receive remuneration; and
- Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Hearing Doctors of NJ has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

### **Right to be Notified if there is a Breach of Your Protected Health information**

You have the right to be notified upon a breach of any of your unsecured protected health information.

**Right to Inspect and Copy**

You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039. If you request a copy of your information, Hearing Doctors of NJ may charge you a reasonable fee for the costs of copying, mailing or other costs incurred in complying with your request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, Hearing Doctors of NJ may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our privacy policy specialist at our office by calling (973)-577-4100 if you have questions about access to your medical record.

**Right to Request Restrictions**

You may ask Hearing Doctors of NJ not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039. Your request must state the specific restriction requested and to whom you want the restriction to apply. Hearing Doctors of NJ is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiologic/health care operation purposes and such information you wish to restrict pertains solely to an audiologic/health care item or service for which you have paid Hearing Doctors of NJ "out-of-pocket" in-full. If Hearing Doctors of NJ believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If Hearing Doctors of NJ does agree to the requested restriction, Hearing Doctors of NJ may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

**Right to Request Confidential Communication**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Hearing Doctors of NJ will accommodate reasonable requests. You must request this by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

**Right to Request Amendment**

You may request an amendment of your protected health information contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you, for as long as Hearing Doctors of NJ maintains the protected health information. You must request for an amendment by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request. In certain cases, Hearing Doctors of NJ may deny your request for an amendment. If Hearing Doctors of NJ denies your request for an amendment, you have the right to file a statement of disagreement with Hearing Doctors of NJ and they may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**Right to an Accounting of Disclosures**

You have the right to receive an accounting of certain disclosures Hearing Doctors of NJ has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. It excludes disclosures Hearing Doctors of NJ may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request.

**Right to Obtain a Paper Copy of this Notice**

You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask Hearing Doctors of NJ to give you a copy of this notice at any time. To obtain a paper copy of this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

**COMPLAINTS OR QUESTIONS**

If you believe your privacy rights have been violated, you may file a complaint with Hearing Doctors of NJ or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with Hearing Doctors of NJ, Please contact our privacy policy specialist at our office by calling (973)-577-4100. All complaints must be submitted in writing. Hearing Doctors of NJ will not retaliate against you for filing a complaint.

**CHANGES TO THIS NOTICE**

Hearing Doctors of NJ reserves the right to change this Notice at any time. The new Notice will be effective for all health information Hearing Doctors of NJ already has about you as well as any information received in the future. You can also obtain a revised Notice at [www.hearingdoctorsnj.com](http://www.hearingdoctorsnj.com) or by contacting Hearing Doctors of NJ at (973)-577-4100.

**Hearing Doctors of NJ**

340 E Northfield Rd #2B,  
Livingston, New Jersey 07039

This Notice is effective as of April, 2020.



HEARING DOCTORS  
OF NEW JERSEY

# Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on the website, and that I will be given a copy of any amended Notice of Privacy Practices upon request.

- This Notice informs me how Hearing Doctors of NJ will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Hearing Doctors of NJ may use and share my health information for other than treatment, payment, and health care operations.
- Hearing Doctors of NJ will also use and share my health information as required/permitted by law.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date



# Pediatric Case History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Gender: (check one) ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Non-Binary

Mother's full name: \_\_\_\_\_

Father's full name: \_\_\_\_\_

Legal guardian's full name(s): \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

## Audiologic History

Was a Newborn Hearing Screening completed: (check one) ☐ Yes ☐ No

**If so**, when: \_\_\_\_\_ Where: \_\_\_\_\_

What were the results (check one): ☐ Pass ☐ Fail/Refer

Additional testing dates: \_\_\_\_\_ Where: \_\_\_\_\_

Does the child:

☐ Consistently respond to sounds ☐ Turn to find a sound source ☐ Startle to loud noise

☐ Respond to his/her name ☐ Enjoy listening to music

Does the child have any sinus/allergy problem (check one) ☐ Yes ☐ No

Symptom(s): \_\_\_\_\_

Treatment(s): \_\_\_\_\_

Does the child snore (check one) ☐ Yes ☐ No

Does the child experience hearing loss: (check one) ☐ Yes ☐ No

**If so**, which ear (check one): ☐ Right ☐ Left ☐ Both

If s/he experiences hearing loss, which best describes it (circle one): ☐ Gradual ☐ Fluctuating ☐ Sudden

When was it diagnosed: \_\_\_\_\_ Who diagnosed it: \_\_\_\_\_

When did you first notice the hearing loss? \_\_\_\_\_

What do you think is the cause of the hearing loss? \_\_\_\_\_

Has the child ever worn or tried a hearing aid or amplifier (check one): ☐ Right ☐ Left ☐ Both

**If so**, when: \_\_\_\_\_

What type and/or style of hearing aid or amplifier: \_\_\_\_\_

Please describe the experience: \_\_\_\_\_

**PLEASE CHECK ALL OF THE MEDICAL CONDITIONS THAT APPLY:**

- ☐ **Ear pain** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
- ☐ **Ear drainage** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both  
Frequency of episodes: \_\_\_\_\_ Drainage Color: \_\_\_\_\_ Texture: \_\_\_\_\_ Odor: \_\_\_\_\_
- ☐ **Dizziness or unsteadiness**  
If checked Is the dizziness accompanied by: *(check all that apply)*  
☐ Vomiting ☐ Nausea ☐ Ear Noises/Tinnitus  
If So, when \_\_\_\_\_
- ☐ **Ear malformations** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
- ☐ **History of ear infections** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
- ☐ **Previous ear surgery** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both  
If so, when: \_\_\_\_\_
- ☐ **Sinus/allergy problems** \_\_\_\_\_
- ☐ **History of earwax buildup** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
- ☐ **Family history of hearing loss** If checked, who is the family member: \_\_\_\_\_
- ☐ **Exposure to loud noise** If so, when: \_\_\_\_\_ What type of noise: *(check all that apply)*  
☐ Military ☐ Recreational ☐ Employment ☐ Other: \_\_\_\_\_  
Do/Did you wear hearing protection devices: *(check one)* ☐ Always ☐ Sometimes ☐ Never
- ☐ **Developmental disorder/delay.** Please explain: \_\_\_\_\_
- ☐ **Other** *(please describe):* \_\_\_\_\_

## Birth History

Hospital/Birthing Center: \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ weeks Age of the mother during pregnancy: \_\_\_\_\_ years

Complications *(check all that apply)*: ☐ Pregnancy ☐ Labor/Delivery ☐ Illness ☐ Accidents

Other Conditions: \_\_\_\_\_

Explain: \_\_\_\_\_

Labor *(check one)*: ☐ Spontaneous/Natural ☐ Induced ☐ Cesarean

Length of labor: \_\_\_\_\_ hours Birth weight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

At birth, did the child have any of the following complications *(check all that apply)*:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Blue color                         | <input type="checkbox"/> Infection of baby and/or mother | <input type="checkbox"/> Premature birth              |
| <input type="checkbox"/> Breathing/respiratory difficulties | <input type="checkbox"/> Jaundice/Hyperbilirubinemia     | <input type="checkbox"/> Sucking/swallow difficulties |
| <input type="checkbox"/> Breech birth                       | <input type="checkbox"/> Low APGAR score                 | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Cesarean birth                     | <input type="checkbox"/> Low birth weight                |   |

Explain: \_\_\_\_\_

## Mother's Pregnancy History

Medications taken by the mother during pregnancy:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

**\*\* Continue on separate page, if needed**

Did any of the following occur during pregnancy (check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cytomegalovirus (CMV) | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Syphilis      |
| <input type="checkbox"/> German measles        | <input type="checkbox"/> Rubella          | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Herpes                |   |  |

Did the mother use tobacco and/or smoke during pregnancy (*check one*) ☐ Yes ☐ No

**If so**, number of cigarettes/uses per day: \_\_\_\_\_

Did the mother drink alcohol during pregnancy: (*check one*) ☐ Yes ☐ No

**If so**, frequency, consumption, what alcohol: \_\_\_\_\_

Did the mother use recreational drugs during pregnancy: (*check one*) ☐ Yes ☐ No

**If so**, what drugs, frequency, and route: \_\_\_\_\_

## Development History

Does the child's development seem normal to you: (*check one*) ☐ Yes ☐ No

Does the child's development seem normal to others: (*check one*) ☐ Yes ☐ No

### At what age did the child first:

Hold his/her head up alone: _____	Crawl: _____
Sit alone without support: _____	Babble: _____
Walk unattended: _____	Feed him/herself: _____
Become toilet trained: _____	Begin to say single words: _____
Combine two-words together: _____	Use full sentences: _____

Describe the child's gross motor skills: \_\_\_\_\_

Has the child been diagnosed with, or treated for, any of the following (*check all that apply*):

- ☐ ADD/ADHD                      ☐ Language Disorder                      ☐ Neurological Problems  
☐ Articulation/speech disorder                      ☐ Learning Disability                      ☐ Physical Impairment  
☐ Other: \_\_\_\_\_

Explain: \_\_\_\_\_

Has the child undergone any of the listed therapies (*check all that apply*):

- ☐ Occupational   ☐ Physical   ☐ Speech/Language   ☐ Vision   ☐ Other: \_\_\_\_\_

Start date: \_\_\_\_\_ Frequency: \_\_\_\_\_

End date: \_\_\_\_\_ Location: \_\_\_\_\_

## Educational History

Does the child attend day care (*check one*):   ☐ Yes   ☐ No

Location: \_\_\_\_\_

Does the child attend pre/school (*check one*): ☐ Yes   ☐ No

Location: \_\_\_\_\_

Grade: \_\_\_\_\_ Contact: \_\_\_\_\_

Special accommodations:

## Family History

Family history of hearing loss (*check one*):   ☐ Yes   ☐ No

**If so**, who and cause: \_\_\_\_\_

Was the patient adopted (*check one*):   ☐ Yes   ☐ No

**If so**, from what country: \_\_\_\_\_ Date of Adoption: \_\_\_\_\_

Other siblings (*check one*):   ☐ Yes   ☐ No

Sibling(s) Name(s)	Date of birth	Relationship ( <i>full, half, step, adopted</i> )

## Home Environment

Primary language spoken at home (*check one*): ☐ English   ☐ Spanish   ☐ Other: \_\_\_\_\_

Other language(s) spoken (*check all that apply*): ☐ English   ☐ Spanish   ☐ Other: \_\_\_\_\_

## Medical History

Child's current medications, supplements, vitamins- prescription or over-the-counter (OTC):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

*\*continue on a separate page, if needed*

Has the child ever been treated with (check all that apply):

☐ Chemotherapy    ☐ Gentamycin    ☐ Radiation    ☐ Streptomycin    ☐ Vancomycin

Allergies (foods, medications, plastics, latex, etc.): \_\_\_\_\_

Has the child had a high fever- above 104oF (check one): ☐ Yes    ☐ No

**If so**, when: \_\_\_\_\_ Treatment(s): \_\_\_\_\_

Last physician appointment date: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:

Has the child been immunized (check all that apply):

<input type="checkbox"/> Anthrax	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rabies
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Rotavirus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Meningococcus	<input type="checkbox"/> Rubella
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Mumps	<input type="checkbox"/> Smallpox
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pertusis	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Hib	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Zoster
<input type="checkbox"/> Human Papillomavirus (HPV)	<input type="checkbox"/> Polio	<input type="checkbox"/> Other: _____

**Has the child experienced any of the following major medical conditions** (check all that apply):

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mumps
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> High Fevers	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Influenza	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Genetic Disorders	<input type="checkbox"/> Malaise	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Malaria	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Measles	<input type="checkbox"/> Vascular Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Other: _____

**Please circle all medical symptoms or conditions that apply:**

Eye problems ( <i>such as blurred or double vision, visual loss</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nose and sinus problems ( <i>such as nose bleeds, sinus surgeries</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular issues ( <i>such as hypertension, chest pain, swelling, palpitations</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory issues ( <i>such as shortness of breath, cough, wheezing</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal issues ( <i>such as nausea, vomiting, weight changes, diarrhea, pain</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Musculoskeletal issues ( <i>such as joint pain, swelling, recent trauma</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological symptoms ( <i>such as numbness, headaches, tingling, seizures, muscle weakness</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric issues ( <i>such as depression, anxiety, compulsions</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endocrine symptoms ( <i>such as frequent urination, hot flashes</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hematologic/lymphatic symptoms ( <i>such as bleeding gums, bruising, swollen glands</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergic/immunologic symptoms ( <i>such as hives, asthma, itching, immune deficiency</i> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Comments related to Review of Symptoms above:** \_\_\_\_\_



# Children's Home Inventory for Listening Difficulties

## Questions for Parent to Answer

Try the following situations with your child or recall how your child has responded under these various situations. Everyone has some difficulty hearing clearly and understanding in some situations. Choose the level on the Understand-O-Meter you think describes your child's abilities most closely and place this number in the blank at the end of each question. This can be very difficult but try to estimate the child's listening abilities as best you can.

Child's Name: \_\_\_\_\_

Parent Completing CHILD: \_\_\_\_\_

## Understand-O-Meter

1. Sit next to your child and look at a book together or talk about something in front of you using familiar words and a normal conversational manner. Talk in a quiet place and sit so your child is not looking at your face as you talk together. How difficult does it seem for your child to hear and understand what you say? \_\_\_\_\_
  2. Gather your family together for a meal at home or in a fairly quiet restaurant. Sit across the table from your child and ask some questions about a familiar topic or event. How difficult does it seem to be for your child to hear and understand ? \_\_\_\_\_
  3. When your child is in his or her bedroom playing quietly, walk into the room and tell or ask the child something. Do not say the child's name or try to get their attention first. How difficult does it seem for your child to hear and understand ? \_\_\_\_\_
  4. Watch a TV show or video (not cartoons) with your child. Ask questions about what was said or events in the show that were understood by listening to the dialogue. How difficult does it seem for him or her to hear and understand what people are saying on the TV show? (Show is seen for the first time and not closed captioned) \_\_\_\_\_
  5. Observe your child playing inside with a friend, brother or sister. Watch for the other child to ask him or her to do something. How easy does it seem to be for your child to hear and understand other children when they talk? \_\_\_\_\_
  6. When your child is watching TV or playing with a noisy toy, walk into the room and talk to him or her without first getting the child's attention. How difficult does it seem for your child to hear and understand the person when the noise from the TV or toy is on? \_\_\_\_\_
  7. Call your child's name from another room when he or she is not able to see you. How difficult does it seem for him or her to hear and realize you are calling? \_\_\_\_\_
  8. Use a clock radio or alarm when it is time for your child to get up. How difficult does it seem to be for him or her to hear an alarm clock or clock radio go off? If no clock is used how difficult is it for him or her to hear your voice and wake up without having to be touched or shaken? \_\_\_\_\_
- 8 **GREAT**  
Hear every word,  
understand everything
  - 7 **GOOD**  
Hear it all, miss part of an  
occasional word, still  
understand everything
  - 6 **PRETTY GOOD**  
Hear almost all the words  
and usually understand  
everything
  - 5 **OKAY BUT NOT EASY**  
Hear almost all the words,  
sometimes misunderstand  
what was said
  - 4 **IT TAKES WORK BUT  
USUALLY CAN GET IT**  
Hear most of the words,  
understand more than half  
of what was said
  - 3 **SOMETIMES GET IT,  
SOMETIMES DON'T**  
Hear words but  
understand less than  
half of what was said
  - 2 **TOUGH GOING**  
Sometimes don't know right  
away that someone is talking,  
miss most of message
  - 1 **HUH?**  
Don't know that  
someone is talking,  
miss all of message



# Children's Home Inventory for Listening Difficulties

9. Observe your child playing with a group of children inside a house. It's noisy. (birthday party, cub scouts, etc.) How difficult does it seem to be for your child to understand what the children are saying as they play as a group? \_\_\_ \_ \_ \_ \_
10. A grandparent, family member or friend wants to talk to your child on the phone. How difficult does it seem to be for him or her to hear and understand what is said over the phone? \_\_\_ \_ \_ \_ \_
11. Observe your child playing outside with other children. How difficult is it for him or her to hear and understand what other children are saying when the children are outside and are not standing close to the child? \_\_\_ \_ \_ \_ \_
12. Go to a crowded store or mall with your child. When you are standing behind the child and he or she is looking at something, ask a question. How difficult does it seem to be for your child to hear and understand what you say? \_\_\_ \_ \_ \_ \_
13. Go into a large room with your child and speak to him or her from across the room. How well does he or she seem to hear and understand what you say? \_\_\_ \_ \_ \_ \_
14. Travel in the car with your child in the backseat. From the front seat say something to your child or ask a question. How easy does it seem for him or her to hear and understand what is said? \_\_\_ \_ \_ \_ \_
15. Sit in a quiet place, face your child and have a conversation or ask questions. How difficult does it seem for him or her to hear and understand what you say? \_\_\_ \_ \_ \_ \_

<b>Total of responses:</b>
<b>Average of responses:</b> (Total divided by 15)

**Comments:**

## Understand-O-Meter

- |   |
|---|
| <b>8 GREAT</b><br>Hear every word,<br>understand everything   |
| <b>7 GOOD</b><br>Hear it all, miss part of an<br>occasional word, still<br>understand everything                              |
| <b>6 PRETTY GOOD</b><br>Hear almost all the words<br>and usually understand<br>everything                                     |
| <b>5 OKAY BUT NOT EASY</b><br>Hear almost all the words,<br>sometimes misunderstand<br>what was said                          |
| <b>4 IT TAKES WORK BUT<br/>USUALLY CAN GET IT</b><br>Hear most of the words,<br>understand more than half<br>of what was said |
| <b>3 SOMETIMES GET IT,<br/>SOMETIMES DON'T</b><br>Hear words but<br>understand less than<br>half of what was said             |
| <b>2 TOUGH GOING</b><br>Sometimes don't know right<br>away that someone is talking,<br>miss most of message                   |
| <b>1 HUH?</b><br>Don't know that<br>someone is talking,<br>miss all of message  |

# S.I.F.T.E.R.

## SCREENING INSTRUMENT FOR TARGETING EDUCATIONAL RISK

by Karen L. Anderson, Ed.S., CCC-A

STUDENT \_\_\_\_\_ TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_ SCHOOL \_\_\_\_\_ DISTRICT \_\_\_\_\_

The above child is suspect for hearing problems which may or may not be affecting his/her school performance. This rating scale has been designed to sift out students who are educationally at risk possibly as a result of hearing problems. Based on your knowledge from observations of this student, circle the number best representing his/her behavior. After answering the questions, please record any comments about the student in the space provided on the reverse side.

1. What is your estimate of the student's class standing in comparison of that of his/her classmates?	UPPER 5	4	MIDDLE 3	2	LOWER 1	ACADEMICS	<input type="checkbox"/>
2. How does the student's achievement compare to your estimation of her/her potential?	EQUAL 5	4	LOWER 3	2	MUCH LOWER 1		
3. What is the student's reading level, reading ability group or reading readiness group in the classroom (e.g., a student with average reading ability performs in the middle group)?	UPPER 5	4	MIDDLE 3	2	LOWER 1		
4. How distractible is the student in comparison to his/her classmates?	NOT VERY 5	4	AVERAGE 3	2	VERY 1	ATTENTION	<input type="checkbox"/>
5. What is the student's attention span in comparison to that of his/her classmates?	LONGER 5	4	AVERAGE 3	2	SHORTER 1		
6. How often does the student hesitate or become confused when responding to oral directions (e.g., "Turn to page . . .")?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
7. How does the student's comprehension compare to the average understanding ability of her/her classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1	COMMUNICATION	<input type="checkbox"/>
8. How does the student's vocabulary and word usage skills compare with those of other students in his/her age group?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
9. How proficient is the student at telling a story or relating happenings from home when compared to classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
10. How often does the student volunteer information to class discussions or in answer to teacher questions?	FREQUENTLY 5	4	OCCASIONALLY 3	2	NEVER 1	CLASS PARTICIPATION	<input type="checkbox"/>
11. With what frequency does the student complete his/her class and homework assignments within the time allocated?	ALWAYS 5	4	USUALLY 3	2	SELDOM 1		
12. After instruction, does the student have difficulty starting to work (looks at other students working or asks for help)?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
13. Does the student demonstrate any behaviors that seem unusual or inappropriate when compared to other students?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1	SCHOOL BEHAVIOR	<input type="checkbox"/>
14. Does the student become frustrated easily, sometimes to the point of losing emotional control?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
15. In general, how would you rank the student's relationship with peers (ability to get along with others)?	GOOD 5	4	AVERAGE 3	2	POOR 1		

## TEACHER COMMENTS

Has this child repeated a grade, had frequent absences or experienced health problems (including ear infections and colds)? Has the student received, or is he/she now receiving, special services? Does the child have any other health problems that may be pertinent to his/her educational functioning?

### The S.I.F.T.E.R. is a SCREENING TOOL ONLY

Any student failing this screening in a content area as determined on the scoring grid below should be considered for further assessment, depending on his/her individual needs as per school district criteria. For example, failing in the Academics area suggests an educational assessment, in the Communication area a speech-language assessment, and in the School Behavior area an assessment by a psychologist or a social worker. Failing in the Attention and/or Class Participation area in combination with other areas may suggest an evaluation by an educational audiologist. Children placed in the marginal area are at risk for failing and should be monitored or considered for assessment depending upon additional information.

### SCORING

Sum the responses to the three questions in each content area and record in the appropriate box on the reverse side and under Total Score below. Place an **X** on the number that corresponds most closely with the content area score (e.g., if a teacher circled 3, 4 and 2 for the questions in the Academics area, an X would be placed on the number 9 across from the Academics content area). Connect the **X**'s to make a profile.

CONTENT AREA	TOTAL SCORE	PASS							MARGINAL			FAIL							
ACADEMICS		15	14	13	12	11	10		9	8		7	6	5	4	3			
ATTENTION		15	14	13	12	11	10	9	8	7		6	5	4	3				
COMMUNICATION CLASS PARTICIPATION		15		14		13		12		11	10	9	8		7	6	5	4	3
		15	14	13	12	11	10	9	8	7		6	5	4	3				
SOCIAL BEHAVIOR		15	14	13	12	11	10		9	8		7	6	5	4	3			