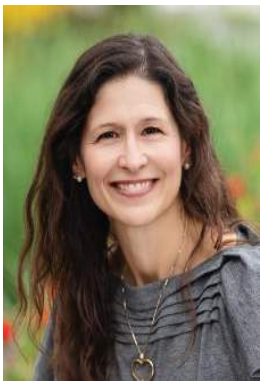
Jackson Gray Medical Building
330 Borthwick Avenue, Suite 209
Portsmouth, NH 03801
603-436-8668
Fax: 436-4499

Professional AUDIOLOGY

Windy Knoll Village
62 Portsmouth Avenue, Unit 10
Stratham, NH 03885
603-778-7620
Fax: 778-0009

Welcome to Professional Audiology

Thank you for calling our office



Erica L. Regan, Aud

Nancy K. Charest, AuD

Racheal R Rush, AuD

Professional Audiology would like to personally welcome you to our office. Our office provides a wide variety of diagnostic and rehabilitative services including hearing screening, routine and diagnostic audiological assessment, hearing aid evaluation, hearing aid dispensing, assistive listening devices, tinnitus evaluation,and many other related services. Our office utilizes the most advanced state-of-the-art technology for both diagnostic and rehabilitative services.

Please visit our website at www.professionalaudiology.com for a complete overview of our services.

Our office participates with most health insurance plans. If you have questions regarding coverage for these services, please call the member services number on your insurance card.

Enclosed you will find all medical forms required by our office to be completed and given to us at the time of your visit. This will save you a considerable amount of time on the day of the examination.

Please bring the following items with you to the appointment.

1. **Insurance Card(s).**
2. **Photo ID.**
3. **Referrals.** If your insurance company requires a referral, please contact your primary care physician. If there is not a proper referral on file, the patient will be responsible for charges incurred. **Medicare mandates a referral for audiology testing.**

Appointment

Patient Name:_____

☐ Portsmouth ☐ Stratham

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Date:_____ Time:_____AM PM

Audiologist:_____

* ***If an appointment is not rescheduled or canceled at least 24 hours in advance, you will be charged a $40 "no-show" fee.***

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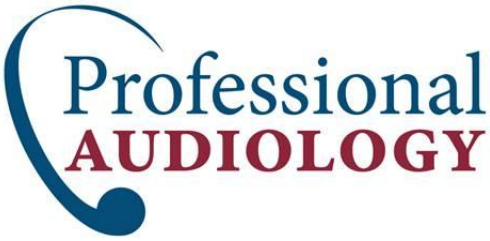

62 Portsmouth Avenue, Suite 10
Windy Knoll Plaza
Stratham, NH 03885
(603) 778-7620
Fax: (603) 778-0009

Child Patient Information Sheet

Please complete prior to appointment as MD does need to review

LAST NAME: _____ FIRST NAME/ MI: _____
ADDRESS: _____ CITY/ST: _____ ZIP: _____
PHONE #: (____)_____ BIRTHDATE: _____GENDER: M F
REFERRED BY: _____
PEDIATRICIAN/PRIMARY CARE PHYSICIAN NAME AND ADDRESS: _____
_____

PARENT/GUARDIAN INFORMATION **EMAIL:**_____

PARENT: _____ OTHER: _____
LAST NAME: _____ FIRST NAME/ MI: _____
STREET 1: _____ STREET 2: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE_____CELL PHONE_____WORK PHONE_____
EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name:_____
Claims Address:_____
_____
Policyholder Name:_____
Relationship to Policyholder: Self___ Child___
Policyholder Date of Birth_____
Policy ID#_____
Policy Group#_____

Secondary Insurance

Insurance Name:_____
Claims Address:_____
_____
Policyholder Name:_____
Relationship to Policyholder Self___ Child_____
Policyholder Date of Birth_____
Policy ID#:_____
Policy Group#_____

I understand that I am financially responsible for the charges for the services provided that may not be covered by my insurance company and that if not covered by my policy contract, I will be responsible for the entire bill.

I also allow Professional Audiology Center to release my records in the event my insurance company requests them for consideration of payment.

Signature of Responsible Party: _____ Date: _____

How did you learn about our office? Please indicate all that apply.

☐ Early Intervention ☐ School ☐ Therapist/Specialist ☐ Friend

☐ Physician ☐ Yellow Pages ☐ Internet ☐ Newspaper/Magazine ☐ Mail Advertising

Child's Pediatrician Name and Address: _____

_____

Father's Name _____ Work # _____

Mother's Name _____ Work # _____

Brothers and Sisters? (names and ages) _____

Parent's chief concerns:_____

When did you first notice this problem?_____

What do you think caused this problem?_____

_____

HEALTH HISTORY:

Yes No

☐ ☐ 1. Were there any problems during the pregnancy, the delivery, or following the birth of this child? If yes, pleaseexplain._____

_____

_____

☐ ☐ 2. During pregnancy, was mother exposed to any viral or bacterial infections? _____

3. Child's gestation age at birth_____weeks; Birthweight_____ Apgar Score (s)_____

☐ ☐ 4. Was the child treated for high bilirubin levels(jaundice)?

☐ ☐ 5. Was oxygen administered to the child following delivery? If yes, explain why and for how long.

_____

☐ ☐ 6. Has this child had any serious illnesses, accidents, or hospitalizations? If yes, please explain.

_____

_____

☐ ☐ 7. Has this child had repeated ear infections? If yes, please describe when they started, how many, and the most recent one:_____

_____

_____

☐ ☐ 8. Is your child presently on any medications? If yes, please indicate which medication and what it is being taken for _____

_____

☐ ☐ 9. Has your child ever been rendered unconscious from a fall or blow to the head? If yes, please explain the date, treatment, and physician._____

_____

☐ ☐ 10. Are there any relatives with known hearing loss? If yes, write the relationship to child, and age of onset.

_____

_____

Yes No

☐ ☐ 11.Are there any relatives with birth defects or abnormalities?_____

_____

12. This child's general health is: Excellent____ Good____ Fair____ Poor____

Please explain any health concerns._____

_____

_____

DEVELOPMENTAL HISTORY:

1. Please describe any concerns that you or your pediatrician has regarding any unusual behavior or slow development, including any speech issues._____
   _____
   _____

   While keeping your child's age in mind, please rate the following:

Motor Coordination and balance:	Excellent	Good	Fair	Poor
Eye/hand coordination:	Excellent	Good	Fair	Poor
General behavior at home:	Excellent	Good	Fair	Poor
Ability to play with other children:	Excellent	Good	Fair	Poor
Ability to keep attention on activity:	Excellent	Good	Fair	Poor
Plays appropriately with toys:	Excellent	Good	Fair	Poor
Ability to solve problems:	Excellent	Good	Fair	Poor
Ability to follow directions:	Excellent	Good	Fair	Poor
Ability to speak clearly:	Excellent	Good	Fair	Poor

EDUCATIONAL HISTORY:

School and Address:_____

School Placement:_____
(Grade) (Teacher)

Progress in School? Excellent Good Fair Poor

Any grades repeated?_____

Previous evaluations and/or training: (when, where, by whom, and results)_____

_____

NOTE TO PARENTS/CARE GIVERS FROM THE AUDIOLOGISTS

If your child is under six years of age, we may ask you to assist during the audiological testing.

Other children in your care cannot accompany you into the test booth as it may be a distraction for the child we are testing. Therefore, we ask that you make appropriate arrangements for child care.

Thank you!

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Patient Name:_____ Date Birth:_____
Home Phone:_____

Privacy Act Acknowledgment

I have been provided the opportunity to review the Notice of Privacy Practice of Professional Audiology. **(**A copy is posted in the office)

_____ _____
(Signature of patient or Guardian) (Relationship)

Patient Record of Disclosure

It is ok to contact me in the following manner (check all that apply)

□ O.K. to send mail to my home address ☐ O.K. to Text ☐ O.K. to Email

□ Home Telephone □ Cellular Phone □ Work Telephone

□ OK to leave message with detailed information on answering machine
□ OK to leave message with spouse or other (Name and Relationship):_____
□ Leave message with call back number only

The audiologists/office staff of Professional Audiology may discuss my medical condition and/or history with: Please check all boxes that apply and fill in name of person. Thank you.

☐ Husband/Wife_____ □ Daughter/Son_____
□ Sister/Brother_____ □ Mother/Father_____
□ Friend_____ □ Other_____

_____ _____
Signature **Date**