Dr. Rodriguez
Audiology & Hearing Center
1000 w 4th st. (575)-623-8474 Fax (575) 623-8220

(Please Print)

Patient Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Sex: M/F Marital Status: married / single / divorced / widowed

Parent/Legal Guardian (if minor): _____ Primary Language: English / Spanish/ other

Patient SS#: _____ Phone #: _____Phone #:_____

E-mail Address: _____

Home Address: _____ City, State, Zip:_____

Mailing Address: _____ City, State, Zip:_____

Employer/School: _____ City, State, Zip:_____

Emergency Contact: _____ Phone#:_____Relation:_____

Please complete the following to the best of your knowledge.

If left blank, the paperwork will be given back for completion.

Primary Insurance Information

Insurance Company: _____ Policy #: _____Group#: _____

Policy holders Name: _____ Date of Birth: _____SS#_____

Patient relationship to policy holder: _____

Secondary Insurance Information

Insurance Company: _____ Policy #: _____Group#: _____

Policy holders Name: _____ Date of Birth: _____SS#_____

Patient relationship to policy holder: _____

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PERMISSION FOR RELEASE OF INFORMATION

Copy of testing should go to:

Referring Provider:_____ Family Physician: _____

City, State: _____ City, State: _____

Phone Number: _____ Phone Number: _____

Any other entities:

1._____ 2._____3._____4._____

I authorize Dr. Rodriguez Audiology & Hearing Center to release audiological records to those persons/agencies listed above.

_____

Signature Relationship Date

RESPONSIBILITY OF ACCOUNT

Patients are responsible for any co-payment due at time of visit, and any deductibles after insurance has processed. Audio Acoustics Hearing Centers, Inc. will file claims for patients with insurance companies as a courtesy to our patients. Patients are responsible for any additional payments if a claim processes out of network. **I understand that I am fully responsible for all charges not covered by my insurance company and agree to pay them in full at time of service, unless otherwise arranged with this office.**

_____

Signature Relationship Date

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Pediatric Communication Profile

Child's Name: _____Date of Birth: _____

First and last name of biological mother: _____/_____
(First) (Last)

In which hospital was your child born? _____/_____
(Hospital) (City/State)

School Attending: _____Grade: _____ Age:_____

1. What is the reason for your visit today?
   _____

2. How often does your child have ear infections? FREQUENT/ MODERATE / OCCASIONAL/ NEVER

3. Most recent infection (if applicable)? YEARS/ MONTHS/ WEEKS/ DAYS/ CURRENT/ UNSURE

4. What medication(s) is your child taking?

_____ _____ _____ _____

5. Has your child had:
   a. Ear surgery or tubes? (Please Specify) _____
   (Type/Date)
   b. Head Injury? (Please Explain) _____
   c. Other surgeries or hospitalizations? (Please Specify)_____
   (Type/Date)

d. Other medical conditions? (Please Explain)
_____

6. Does anyone in the family have a childhood history of hearing loss? Yes No
7. Are there concerns about your child's speech and language development? Yes No
   Describe: _____
   If Yes, is your child currently receiving speech therapy? Yes No
8. Describe your child's school performance: EXCELLENT/ GOOD/ FAIR/ POOR

Pre and Post Natal Risk Factors (Check all that apply)

__ Birth weight less than 1500 grams (3.3 pounds)
__ Severe asphyxia: APGAR scores of 0-3 or failed to institute spontaneous respirations by ten (10) min. or hypotonia persisting to two(2) hours
__ Persistent Fetal Circulation/ Persistent Hypertension
__ Prolonged mechanical ventilation for duration equal to or greater than 10 days
__ Bacterial Meningitis __Haemophilus influenza
__ Ototoxic Medications including aminoglycosides used more than 5 days (e.g. gentamicin), or loop diuretics (e.g. furosemide).
__ Hyperbilirubinemia
__ Congenital or perinatal infections: (Check all that apply)
__Toxoplasmosis __Cytomegalovirus __Rubella
__Syphilis __Herpes Simplex Virus __ Other _____
__ Anatomical defects of the head and neck: (Check all that apply)
__ Down Syndrome __Ear Tags __Microtia/atresia of the ear __ Cleft lip/palate
__Other_____
__ Stigmata or other findings associated with a Syndrome known to include hearing loss (e.g. Waardenburg, Ushers)
__ Other _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Dr. Rodriguez Audiology and Hearing Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat ma as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Dr. Rodriguez Audiology and Hearing Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Feral Regulations, should Dr. Rodriguez Audiology and Hearing Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U. S. mail or, if I agree, email)
I wish to have the following restrictions to the use or disclosure of my health information:
_____
I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.
Patient's Signature_____
Date_____

FOR OFFICE USE ONLY
Consent received by _____ on _____.
Consent refused by patient, and treatment refused as permitted.
Consent added to the patient's medical record on _____.