Kos/Danchak
AUDIOLOGY & HEARING AIDS

CHILD PATIENT INFORMATION

Date: _____ SS #: _____

Name: _____
First Middle Last

Birth Date: _____ Age: _____ Sex: _____

Home Address: _____
Street City State ZIP

Mailing Address (if different): _____

With whom does this minor child live? _____

Who has legal guardianship? _____

Father's Name: _____ Birth Date: _____ SS #: _____

Home address if different from child's: _____

Home Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Employment Address: _____ Business Phone: _____

Can calls/messages be received? _____ When? _____

Mother's Name: _____ Birth Date: _____ SS #: _____

Home address if different from child's: _____

Home Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Employment Address: _____ Business Phone: _____

Can calls/messages be received? _____ When? _____

Who referred you to this office? _____

Who will be responsible for payment? _____

Name any insurance program or agency that will provide coverage for audiological services and hearing instruments for the child, and name the insured member.

_____

Permission to Release Information:

_____
Name Date

_____
Guardian's Signature

Arlington Office - 905 W. Mitchell St., Arlington, TX 76013 - (817) 277-7039
Fort Worth Office - 904 Pennsylvania Ave., Fort Worth, TX 76104 - (817) 332-8817
kdaud.com

Has the child's hearing been tested before? ☐ Yes ☐ No If yes, when and where?

_____

What recommendations were made? _____

When did you first suspect a hearing problem? _____

Which do you think is the better ear? ☐ Right ☐ Left

What is believed to be the cause of the hearing loss? _____

Did the hearing loss happen gradually or suddenly? _____

Does hearing seem to fluctuate? _____

What reaction is there to loud sounds? _____

Do other family members have hearing loss? ☐ Yes ☐ No Who? _____

Is there ringing or other noise in the ears? _____

Any dizziness? ☐ Yes ☐ No When? _____

Has an ear doctor been consulted? ☐ Yes ☐ No Who? _____

Has the patient had earaches, infections or drainage? _____

When? Who treated these? _____

Name any medications the patient is currently taking: _____

Family Doctor/Pediatrician: _____ Phone #: _____

Doctor's Address: _____

Where is there trouble hearing? ☐ TV ☐ Groups ☐ School ☐ Noise ☐ Large Rooms

Does the patient hear some people better than others? _____

Can the patient use the telephone and hear it ring? _____

Does the patient use an amplifier? In which ear? _____

Which hand does the patient write with? _____

Does the patient rely on others to "translate" for them when they can't understand? _____

Has the patient tried or used a hearing aid? _____

If yes, complete the following:

Type(s): _____ Brand(s): _____

Ear(s) Fitted: _____ When Purchased? _____

Performance of present/past instrument(s): _____

Does the patient have any physical disabilities that might make it difficult to manipulate small controls? _____

Does the patient wear glasses? ☐ Yes ☐ No If so, when? _____

_____

Name of Person Completing this Form Date