THE AFA BALANCE & HEARING INSTITUTE
A.T. STILL UNIVERSITY OF HEALTH SCIENCES

4838 E. Baseline Road. Suite #126. Mesa, Arizona 85206
Phone: (480)265-8067 Fax: (480)656-6316
Web: www.TheAFAInstitute.com Email: AFAInstitute@atsu.edu

Due to new HIPPA regulations ALL information must be filled out, otherwise we will not be able to process your claim and you will be billed for medical services.

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____/_____/_____

GENDER: MALE: _____ FEMALE: _____

PARENTS / GUARDIAN

MOTHERS NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____/_____/_____

HOME PHONE #: _____ CELL PHONE #: _____

EMPLOYER: _____ WORK PHONE # _____

ADDRESS: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____/_____/_____

HOME PHONE #: _____ CELL PHONE #: _____

EMPLOYER: _____ WORK PHONE # _____

ADDRESS: _____

MAY WE LEAVE MESSAGES FOR YOUR AT THESE NUMBERS? ☐ YES ☐ NO
DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CHILD'S CARE ORTREATMENT WITH ANY PARTY (INCLUDING FAMILY MEMBERS BESIDE YOURSELF? IF YES, WITH WHOM? _____

REFERRING PHYSICIAN NAME: _____

CONTACT NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT): _____ DATE OF BIRTH: _____

INSURANCE THROUGH EMPLOYER? ☐ YES ☐ NO (IF YES, EMPLOYER NAME: _____

INSURED ID #: _____GROUP #: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CARRIER

POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT): _____ DATE OF BIRTH: _____

INSURANCE THROUGH EMPLOYER? ☐ YES ☐ NO IF YES, EMPLOYER NAME: _____

INSURED ID #: _____ GROUP #: _____ RELATIONSHIP TO PATIENT: _____

Authorization to Release information and assignment of Benefits

I authorize payments of medical benefits to the provider for service rendered or to be rendered in the future without obtaining my signature on each claim submitted. I also authorize the release of any medical information necessary. I understand that I could be subject to a cancellation fee for each appointment missed where no notice is given or less than 24 hours of notice given. I am responsible for all charges regardless of insurance coverage. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand this office policy and procedure.

SIGNATURE: _____ **DATE:** _____

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AUDIOLOGY PEDIATRIC HISTORY

Patient Name: _____ **Age:**___ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___

Person completing this form: _____ **Relationship to child:** _____

Referring Physician: _____ **Has this child been seen here in the past?** YES / NO

Do you think your child has hearing difficulty? Yes___ No___ Sometimes___ **Which ear(s)?**_____

When did you notice this problem? _____

Did your child pass his/her newborn hearing screening at birth? Yes___ No___ Not sure(?)____

Are there concerns about this child's speech / language? Yes____ No____

If yes, what are the concerns? _____

Does this child have any of the following: (please check Yes or No)

Frequent colds or illness?	□Yes □No	When was most recent?
Frequent ear infections?	□Yes □No	When was most recent?
Discharge / Drainage from ears?	□Yes □No	Please describe:
Allergies or Sinus problems	□Yes □No	Please describe:
History of ear surgery (including tubes)?	□Yes □No	Please describe:
Family history of hearing loss?	□Yes □No	Please describe:
Family history of speech delays?	□Yes □No	Please describe:
Poor balance or walking ability	□Yes □No	Please describe:

MEDICAL HISTORY: (please check or list any injuries or illness for which the child has ever received treatment)

- □ Anoxia / Hypoxia (low oxygen)
- □ Allergies / Sinus Problems
- □ Anemia
- □ Blood disease
- □ Cancer
- □ Cerebral Palsy
- □ Chicken Pox
- □ Cleft Palate or Lip
- □ Cytomegalovirus (CMV)
- □ Diabetes
- □ Genetic Disorder / Syndrome
- □ Head Injury
- □ Headaches / Migraine
- □ Heart abnormality
- □ Hepatitis (A,B or C)
- □ Herpes
- □ Head or Face abnormality
- □ High Fever
- □ HIV / AIDS
- □ Jaundice (hyperbilirubinemia)
- □ Kidney problems
- □ Liver problems
- □ Measles / Mumps
- □ Meningitis
- □ Rubella
- □ Scarlet fever
- □ Seizure Disorder
- □ Stroke
- □ Syphilis
- □ Toxoplasmosis
- □ Thyroid Disorder
- □ Tuberculosis

OTHER:_____

_____

_____

Pregnancy / Birth History:

	Please Circle One:		
1. Did the child's mother have any problems or serious illnesses during pregnancy?	Yes	No	Unknown
2. Was the child's mother taking any drugs, alcohol or medications during pregnancy?	Yes	No	Unknown
3. Were there any problems encountered by the mother or child during delivery?	Yes	No	Unknown
4. Was the child born pre-term (premature)?	Yes	No	Unknown
5. Was the child born via caesarian (C-section) delivery?	Yes	No	Unknown
6. Is the child a twin / triplet?	Yes	No	Unknown
7. Did the child appear yellow (jaundiced) or blue (hypoxia) at birth?	Yes	No	Unknown
8. Was the child's weight low at birth (less than 1.5kg or 3.5lbs)?	Yes	No	Unknown
9. Was the child given oxygen after birth for any reason?	Yes	No	Unknown
10. Was the child kept in intensive care unit after birth for any reason?	Yes	No	Unknown

Developmental History:

1. Have the child's developmental milestones been age appropriate?	Yes	No	Unknown
2. Has the child been diagnosed with an expressive/receptive speech delay?	Yes	No	Unknown
3. Are there multiple languages spoken in the home?	Yes	No	Unknown
4. Has the child been diagnosed with autism / pervasive development disorder (PDD)?	Yes	No	Unknown
5. Has the child been diagnosed with Down Syndrome?	Yes	No	Unknown
6. Has the child been diagnosed with ADD / ADHD?	Yes	No	Unknown
7. Is the child currently being evaluated for any developmental or social problems?	Yes	No	Unknown
8. Is the child receiving any therapy (speech, physical therapy, developmental therapy)?	Yes	No	Unknown

SURGICAL HISTORY (please list any surgeries and/or operations that your child has had)

_____

_____

_____

MEDICATIONS (please list any medications that your child is taking and what they are taking them for)

_____

_____

_____

NOTES (PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

_____

_____

_____

_____

Ref criteria:

1. Visible congenital or traumatic deformity of the ear
2. Visible evidence of impacted cerumen or foreign body in canal
3. Otitis Media / Hx of active drainage from the ear in previous 90 days
4. Hearing loss (Initial Diagnosis)
5. Hx of sudden hearing loss or progressive HL within 90 days
6. Unilateral HL of sudden or recent onset within 90 days
7. Conductive HL: Audiometric A-B gaps $\geq$ 15dB at 500-2000Hz
8. Otalgia or ear discomfort
9. Inflammation of the ear
10. Acute or chronic dizziness (balance disturbance)
11. Tinnitus-Initial evaluation /recent onset
12. Blocked feeling in ear
13. Spontaneous nystagmus
14. Symptoms associated with ototoxic drugs
15. Perforated tympanic membrane

Audiologist Initials: _____

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PATIENT APPOINTMENT INFORMATION

YOUR APPOINTMENT IS SCHEDULED ON THIS DATE: ……

AT THIS TIME: ……..

PRIOR TO YOUR APPOINTMENT, PLEASE MAKE CERTAIN TO:

1. Complete the enclosed forms.
2. Bring the completed forms with you to the appointment (alternatively you may also fax or email them ahead of time).
3. Bring your insurance card and a valid I.D. to the appointment.
4. Plan ahead and arrive ***at least*** 15 minutes early.
5. If you are scheduled for balance (dizziness) testing, please review the *pre-test instructions* at least 24 hours prior to your appointment.

Note: Testing procedures take time and we have appointments scheduled throughout the day. For this reason, if you arrive late, you may be forced to wait or we may have to reschedule your appointment at our discretion.

If you have any questions or require further directions, please contact us at (480)265-8067.