ROCKET HEARING & BALANCE

5 N Maple Avenue, Suite 100
La Plata, Maryland 20646
410-696-3669 ph | 410-695-3769 fax

First visit
Follow-up
Annual check

PEDIATRIC HEARING HEALTH QUESTIONNAIRE

Patient's Name _____ Today's Date _____

Name of person completing form _____

Relationship to patient _____

Describe the purpose of today's visit _____

Circle Y for Yes or N for No for each of the following statements about this child's hearing health.

Do you think your child has a hearing loss?	Y N	If yes, which ear?	R L Both	
Do family or friends think your child has hearing loss?	Y N			
Does your child's teacher suspect hearing loss?	Y N			
Does your child have difficulty hearing in a group?	Y N			
Does your child have difficulty hearing on the phone?	Y N			
Does your child have difficulty hearing the television?	Y N			
Has your child ever had wax removed by a doctor?	Y N	If yes, which ear?	R L Both	
Has your child reported pain or fullness in their ears?	Y N	If yes, which ear?	R L Both	
Does your child have any active ear discharge?	Y N	If yes, which ear?	R L Both	
Has your ever reported dizziness?	Y N			
Does your child have any eye or vision difficulties?	Y N			
Has your child experienced sudden hearing loss?	Y N	If yes, which ear?	R L Both	
Is there any family history of hearing loss?	Y N			
Is there any history of loud noise exposure?	Y N			
Has your ever had surgery on their ears?	Y N	If yes, which ear?	R L Both	
Has your child reported ear ringing or buzzing?	Y N	If yes, which ear?	R L Both	

When was your child's last appointment for hearing test? _____

If applicable, where was the last test performed? _____

Does your child have and/or use hearing aids? Y N If yes, describe them and your success using them.

_____

Describe what activities your child enjoys: _____

Describe how your child interacts with other children and adults: _____

Describe any pregnancy and/or birth complications:

_____

Was there anything that wasn't covered that you would like to share?

_____

For children aged 3 and older, please complete the questionnaire below.

Each item is a general scenario encountered in the home environment between a child and parent.

On a scale from 1 to 8, please chose the rating that most closely describes your experiences.

		SCALE	
1	*Imagine you are sitting next to your child, looking at a book together or talking about something in front of you using familiar words and a normal conversational manner. You are talking in a quiet place and sitting so that your child is not looking at your face while you talk together.* How difficult does it seem for your child to hear and understand what you say? _____	8	**GREAT** Hear every word, understand everything
2	*Imagine your family is together for meal at home or in a quiet restaurant. You are sitting across the table from your child asking questions about a familiar topic or event.* How difficult does it seem to be for your child to hear and understand? _____	7	**GOOD** Hear it all, miss part of an occasional word, still understand everything
3	*Imagine your child is in his or her room playing quietly. You walk into the room and tell or ask your child something without saying his or her name first to get his or her attention.* How difficult does it seem for your child to hear and understand? _____	6	**PRETTY GOOD** Hear almost all of the words and usually understand everything
4	*Imagine you are watching a new TV show or a new video (not cartoons) with your child. You ask a question about what was said or about event s in the show that were understood by listening to the dialogue.* How difficult does it seem for your child to hear and understand what people are saying on the TV show? _____	5	**OKAY BUT NOT EASY** Hear almost all of the words, sometimes misunderstand what was said
5	*Imagine you are watching your child play inside with a friend or sibling. The friend or sibling asks your child to do something.* How easy is it for your child to hear and understand other children when they talk? _____	4	**IT TAKES WORK BUT CAN USUALLY GET IT** Hear most words, understand more than half of what was said
6	*Imagine your child is watching TV or playing with a noisy toy. You walk into the room and start talking to your child without getting his or her attention first.* How difficult does it seem for your child to hear and understand you talking with a noisy toy or TV in the background? _____	3	**SOMETIMES GET IT, SOMETIMES NOT** Hear words but understand less than half of what is said
7	*Imagine that your child is in another room, down a hallway, or out of sight. You call your child's name to ask him or her to come to you.* How difficult does it seem for him or her to hear and realize you are calling? _____	2	**TOUGH GOING** Sometimes don't know right away that someone is talking, miss most of message
8	*Imagine that you use an alarm clock or other alarm when it is time for your child to wake up in the morning.* How difficult does it seem to be for him or her to hear an alarm go off? If no clock is used, how difficult is it for your child to hear your voice? _____	1	**MISSED IT COMPLETELY** Don't know that someone is talking, miss all of the conversation

9	*Imagine that your child is playing noisily with a group of children in a room (think kids birthday party or cub scout meeting).* How difficult does it seem to be for your child to understand what the children are saying as they play in a group? _____	8	**GREAT** Hear every word, understand everything
10	*Imagine that a grandparent, family member, or friend want to talk to your child on the phone.* How difficult does it seem to be for your child to hear and understand over the phone? _____	7	**GOOD** Hear it all, miss part of an occasional word, still understand everything
11	*Imagine that you are watching your child play outside with a group of other children.* How difficult does it seem for your child to hear the other children outside when they are not close to your child? _____	6	**PRETTY GOOD** Hear almost all of the words and usually understand everything
12	*Imagine that you go to a crowded store or mall with your child. Your child is in an aisle looking at something and you walk up from behind to ask a quesetion about it.* How difficult does it seem to be for your child to hear and understand what you say? _____	5	**OKAY BUT NOT EASY** Hear almost all of the words, sometimes misunderstand what was said
13	*Imagine that you go into a large room and see your child on the other side. You speak to your child from across the room.* How difficult does it seem for your child to hear and understand what you say? _____	4	**IT TAKES WORK BUT CAN USUALLY GET IT** Hear most words, understand more than half of what was said
14	*Imagine that you are travelling in the car with your child in the backseat. From the driver's seat, you say something to your child or ask a question.* How difficult is it for you child to hear and understand what you say? _____	3	**SOMETIMES GET IT, SOMETIMES NOT** Hear words but understand less than half of what is said
15	*Imagine that you are seated in a quiet room facing your child. You are having a conversation and ask a follow-up question.* How difficult does it seem for your child to hear or understand what you say? _____	2	**TOUGH GOING** Sometimes don't know right away that someone is talking, miss most of message
		1	**MISSED IT COMPLETELY** Don't know that someone is talking, miss all of the conversation

Are there any other specific situations that you observe your child having difficulty with hearing or understanding?

_____

Besides speech, are there any other sounds that your child seems to routinely miss or be unaware of?

_____

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GENERAL MEDICAL HISTORY

Patient's Name _____ Today's Date _____

Describe the purpose of today's visit: _____

When was your last hearing test? _____

Have you ever had ear surgery? _____

Is there any family history of hearing loss? _____

Please indicate if you are experiencing any of the following:

- ☐ Ear pain
- ☐ Ear fullness
- ☐ Ear drainage
- ☐ Dizziness
- ☐ Headache
- ☐ Nausea
- ☐ Sudden loss of hearing
- ☐ Difference in hearing between right and left ear
- ☐ Ringing in one or both ears
- ☐ Prolonged loud noise exposure
- ☐ Sensitivity to sound
- ☐ Changes in vision

Please indicate if you are being treated for any of the following:

- ☐ Ear infection
- ☐ Heart condition
- ☐ Blood disorder
- ☐ Blood pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Migraine
- ☐ Stroke
- ☐ Seizure
- ☐ Head injury
- ☐ Neurological disorder
- ☐ Other long term illness

Please describe any current or previous experience with hearing aids and/or other hearing assistive devices:

_____
_____

Please descrbe previous surgeries, if any:

_____
_____
_____
_____
_____

Please list current medications below (or, if you carry a copy of your medications list, please provide a copy):

_____
_____
_____
_____
_____

Is there anything else that you would like for us to know before treating you?

_____
_____

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PATIENT INTAKE

Patient's Name _____ Today's Date _____
DOB _____ SSN _____ Gender _____ Age _____
Street Address _____
City _____ State _____ Zipcode _____
Home phone _____ Cell phone _____ Email _____
Preferred method of contact _____

Is it okay to leave reminder messages on your voicemail? Y N
Is it okay to email reminder messages? Y N

Occupation _____ Employer _____

Marital Status _____ Spouse's Full Name _____

Emergency Contact _____ Phone Number _____
Relationship to Patient _____

Primary Care Physician _____ Phone Number _____
Referring Physician _____ Phone Number _____

May we send today's test results directly to your physicians listed above? Y N

How did you hear about our office? _____

INSURANCE INFORMATION Please provide insurance cards upon arrival.

Primary Insurance Company _____	Secondary Insurance Company _____
ID Number _____	ID Number _____
Group Number _____	Group Number _____
Name of Policy Holder _____	Name of Policy Holder _____
Policy Holder's DOB _____	Policy Holder's DOB _____

RESPONSIBLE PARTY FOR BILLING

Responsible Party's Full Name _____
Home Address _____
Phone Number _____ Relationship to Patient _____

PATIENT PRIVACY POLICY

I hereby give consent to Rocket Hearing & Balance to disclose test results to the physician(s) named on the previous page and my personal information disclosed to the insurance company(s) listed on the previous page and their agents for the purpose of obtaining payment for services and determining insurance benefits payable. I understand that I am fianancially responsible for all charges whether or not paid for and/or covered by my insurance company(s). I authorize the use of my signature on all submissions. I understand that I have the option to request a hard copy of the full privacy policy.

Signature _____ Date _____

I hereby authorize Rocket Hearing & Balance to reasonably use and/or disclose my health information to execute treatment, activities of billing and payment, and other healthcare operations as necessary. I understand that my health information specifically identifies me or can be used to identify me. While I understand that this authorization is voluntary, I also understand that if I refuse to consent, services may be withheld from me. I also understand that I have the ability to revoke this consent at any time and the revocation must be received in writing. I further understand that any actions taken by Rocket Hearing & Balance prior to receiving written revocation will not be affected.

Signature _____ Date _____

I hereby authorize Rocket Hearing & Balance to disclose information about my care and/or account to the following:

Spouse		Care Taker	
Primary Care Physician		Other	
Neurologist		Other	
ENT Physician		Other	

Signature _____ Date _____

I hereby authorize payment of medical benefits billed to my insurance to be issued to Rocket Hearing & Balance. I accept responsibility for payment for any services(s) or product(s) provided to me that is or are not covered by my insurance company(s). I also accept responsibility for fees that exceed the payment made by insurance company(s) if Rocket Hearing & Balance does not participate with my insurance or if I otherwise agree in writing. I agree to pay all copayments, coinsurances, and/or deductibles in full at the time services are rendered or upon receipt of invoice by mail.

The above policy will remain in effect for as long as I am under the care of a provider at Rocket Hearing & Balance, or if otherwise notified. My signature represents my review, understanding, and acceptance of the above billing policies.

Signature _____ Date _____

Printed Name _____

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Authorization to Release Information

Patient's Name _____ Today's Date _____

I, the above named patient, hearby authorize Rocket Hearing & Balance, to release and/or receive protected health information, including but not limited to diagnoses, health reports, test results, recommendations, and treatment guidelines for myself or the individual listed below.

Name _____ Date of birth _____

I understand that these permissions may be revoked at anytime by notifying Rocket Hearing & Balance in writing at the address listed above. I understand that the written revocation must be signed and dated with a date that is later than the date on this authorization form. Any revocation will not affect any actions taken before the receipt of the written revocation.

I further understand that this authorization will remain effective from the date of my signature for one full year. I understand that all information will be handled confidentially in compliance with all applicate state and federal laws.

If I have any questions, I understand that I am welcome to contact Rocket Hearing & Balance at the above listed phone number.

_____ _____
Signature of patient/guardian Date

_____ _____
Signature of witness Date