Hill Country Audiology Service
703 Hill Country Drive, Suite 102
Kerrville, TX 78028
830-792-4060; FAX 830-792-5288

Date: _____

☐ New Patient Registration

☐ Update of Current Patient

Patient Name: _____ Social Security Number: _____

Street Address: _____

City, State, Zip Code: _____ Gender: ☐ Male ☐ Female

Mailing Address (if different): _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

E-mail Address: _____ May we contact you via e-mail: ☐ YES ☐ NO

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse, if appl.: _____

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Status: ☐ Full-Time ☐ Part-time ☐ Retired

Occupation: _____ Work Phone: _____

If Child, Name of School/Childcare Facility: _____

Responsible Party: _____ (Complete if Different Than Above)

Date of Birth: _____ Social Security Number: _____

Address: _____

Employer: _____ Relationship to Patient: _____

Primary Insurance - Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Insurance Company: _____ Policy #: _____

Group #: _____

Secondary Insurance - Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Insurance Company: _____ Policy #: _____

Group #: _____

How did you hear about our office? (Please check ALL that apply):

☐ Physician ☐ Newspaper ☐ Phonebook ☐ Friend ☐ Family Member

☐ Internet ☐ Website ☐ Other: _____

HILL COUNTRY AUDIOLOGY SERVICE

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Doctors of Audiology
Fellows, American Academy of Audiology
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Kerrville, TX 78028

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Purpose: This Privacy Notice is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Privacy Notice explains to you, a patient of this practice, how your medical information may be used and disclosed, and how you can get access to your medical information.

1. OUR COMMITMENT TO YOU REGARDING MEDICAL INFORMATION

This practice is determined to protect the privacy of your medical information. In order to provide you with quality care and service, as well as comply with the law, we must create a medical record for you and document the care and services you receive at this practice. Federal law requires us to ensure the confidentiality of your medical record. This notice will explain to you which circumstances require us to use or disclose your medical information. We also describe your rights, as well as our obligations, regarding the use and disclosure of medical information.

2. WHAT THE LAW REQUIRES US TO DO

The Federal Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and terms of this notice at any time, provided that the law permits the change.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Following is a description of the different circumstances that may require this practice to use or disclose your medical information. For any of these circumstances, you can submit a written request restricting our use or disclosure of your medical information for treatment, payment, or healthcare operations. You may also request, in writing, that we only disclose your medical information to certain individuals responsible for your care, or the payment for your care. Legally, we are not required to agree to your request. If we do agree to honor the written request, we then must abide by our agreement unless in those situations required by law, in emergencies, or when information is necessary to treat you. If you wish to revoke any previously written request, you may do so in writing.

4. ACKNOWLEDGMENT FORM

*** To be kept of file at Hill Country Audiology Service - please sign and return to Receptionist ***

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____ Date: _____

5. PATIENT INFORMATION RELEASE

I, _____ give permission for the following person(s) to have access to my medical records from Hill Country Audiology Service.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Patient Name: _____ Date: _____

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Jeffrey Sirianni, AuD
Eric Hicks, AuD
Doctors of Audiology

Pediatric Questionnaire

1. What is the reason for having this child tested? (Check all that apply)

   ☐ Failed hearing screening ☐ Chronic ear infections ☐ Suspected hearing loss

   ☐ Delayed speech development ☐ School requirement ☐ Unsure

2. Where was this child born? _____

   What was the result of the newborn hearing screening?

   Passed both ears ☐ Failed both ears ☐ Passed/Failed one ear ☐ Unsure ☐

   If either or both ears failed, was this child rescreened? Yes ☐ No ☐

   What was the result of the rescreening? _____

3. Was there any gestational complications? No ☐ Yes ☐ Explain: _____

   Was this child born full term? ☐ or premature? ☐ (How many weeks premature? ___)

   Was this child born vaginally? ☐ or via Caesarean section? ☐

   Was there any complicatations during birth? No ☐ Yes ☐ Explain: _____

   Did this child have to spend any time in neonatal intensive care? No ☐ Yes ☐ How long: _____

4. Does this child have a history of nasal allergies (runny rose, congestion)? Yes ☐ No ☐

   What has been the normal course of treatment? _____

5. Does this child have a history of chronic ear infections? Yes ☐ No ☐ Unsure ☐

   If yes, how many recent ear infections within the last 6 months? _____

   What has been the normal course of treatment? _____

   Has ventilation tubes ever been suggested or recommended? Yes ☐ No ☐ Unsure ☐

   Has ventilation tubes ever been placed? Yes ☐ No ☐ How many times? _____

6. Is there hearing loss on either side of the family? Mother: Yes ☐ No ☐ Unsure ☐

   Father: Yes ☐ No ☐ Unsure ☐

7. Does this child alert to environmental sounds (turning head, moving eyes)? Yes ☐ No ☐

   Does this child respond to his/her name when called upon from behind? Yes ☐ No ☐

   Does this child follow simple verbal instructions (ie. get shoes, come to table)? Yes ☐ No ☐

   Does this child appear to struggle in school according to teachers, grades? Yes ☐ No ☐

8. Do this child have any other medical conditions what should be noted? _____

   _____