Infant Registration Form (Birth to Six Months)

Today's Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ DOB: _____

Preferred Name: _____

Gender: M / F / NB / Other: _____ Pronouns: She/Her He/Him They/Them Other: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Primary Phone Number: _____ (Circle one: Home / Work / Cell)

Secondary Phone Number: _____ (Circle one: Home / Work / Cell)

Preferred Method of Contact: Phone / Text Message / Email

Mother and Father's Full Name: _____

Guardian/Caregiver: _____ Relationship: _____ Phone Number: _____

REFERRAL INFORMATION (How did you hear about us?)

Referring Physician: _____

The patient is responsible for paying for the services rendered during today's visit. NHS will bill insurance as a courtesy. Copies of insurance cards are required for ALL insurance companies through which you have coverage.

Primary Insurance: _____

Sponsor's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance:_____

Sponsor's Name: _____ DOB: _____ Relationship: _____

TRICARE Insurance Holders:_____

Sponsor's Name: _____ DOB: _____ Relationship: _____

SSN: _____ Address (if different than above): _____

By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____ Date Signed: _____

Patient Name: _____ Date: _____

Parent/Guardian Name: _____

Reason for visit: _____

Where was your child born (city/state)? _____

Name of birth hospital or center: _____

Was your child full-term (36–40 weeks)? Or premature (<36 weeks)? _____

If premature, how many weeks? _____

Were there any complications throughout pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Were there any complications with the birth? ☐ Yes ☐ No

If yes, please explain: _____

Was your child hospitalized (NICU) after birth? ☐ Yes ☐ No

If yes, please explain: _____

Was your child's hearing screened at birth? ☐ Yes ☐ No

If yes, Right Ear Results: _____ Left Ear Results: _____

Is there a family history of hearing loss (present at birth)? ☐ Yes ☐ No

Were any of the following issues present at birth? (Circle all that apply)

Low Birth Weight Difficulty Gaining Weight Difficulty Breathing Jaundice None

Has your child been diagnosed with any of the following conditions? (Circle all that apply)

Cytomegalovirus (CMV)	Cleft Lip/Palate	Congenital Syphilis
Down Syndrome	Waardenburg Syndrome	Branchio-oto-renal Syndrome
Fetal Alcohol Syndrome	Usher Syndrome	CHARGE Syndrome
Stickler Syndrome	Alport Syndrome	Charcot-Marie-Tooth Syndrome
None	Other: _____	

Please list any other important information you feel we should know: _____

_____

_____

Signature: _____ Date Signed: _____

(Please note: All information is completely confidential and available only per release of the patient.)

Patient Name: _____ Date: _____

I have had an opportunity to review or have received a copy of Northern Hearing Services Inc.'s Notice of Privacy Practices documents.

I authorize Northern Hearing Services Inc. to discuss my health information with the individual(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Printed Name: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The individual refused to sign the acknowledgment.

_____ A communication barrier prohibited us from obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining the acknowledgment.

_____ Other: _____