Pediatric Case History

West Texas Rehabilitation Center
4545 HartfordSt.
Abilene, TX 79605
Phone: (325) 793-3490
Fax: (325) 793-3581
westtexasrehab.org

Patient Name: **MR#:**

DOB: **Age:** **Gender:**

Mother/Caretaker Name:_____ Father/Caretaker Name:_____

PEDIATRIC HEARING HISTORY
Do you have any concerns about your child's hearing? **Yes / No**
If yes, briefly explain:_____

Did your child pass their newborn hearing screening? **Yes / No / Don't know**

Has your child received a hearing test since birth? **Yes / No**
If yes: Where:_____ When:_____
Was your child diagnosed with a hearing loss? **Yes / No**

Does anyone in your child's family (blood relation) have hearing loss? If so please explain:
_____

Has a hearing device ever been recommended for your child? **Yes / No**
If so when?_____

Does your child currently wear a hearing aid or a hearing device? **Yes / No**

Has your child been exposed to any loud noises or sounds (e.g. gunfire, loud music, firecrackers, large engines etc.)? **Yes / No** If so, what type?_____

BIRTH AND PREGNANCY HISTORY:
Where was your child born? Hospital:_____ City:_____ State:_____
Length of pregnancy:_____

Please check any of the conditions that occurred during pregnancy:
- ☐ Tobacco use
- ☐ Substance abuse
- ☐ CMV
- ☐ Rubella/German measles
- ☐ Rh incompatibility
- ☐ Other medications/illnesses

If you checked any of the boxed above, please describe:
_____
_____

At birth, did your baby experience any of the following complications (please check all that apply):
- ☐ Jaundice
- ☐ Low birth weight
- ☐ Breathing/respiratory difficulties
- ☐ Special Neonatal care or NICU
- ☐ Physical abnormalities at birth (such as cleft lip/palate, unusually shaped ear)

If you checked any of the conditions above, please describe:

MEDICAL HISTORY:
Does your child have a history of ear infections? **Yes / No** -1
If yes: First Occurrence:_____ Frequency:_____
Most recent:_____ Treatment(s):_____

Has your child ever had ear tubes surgically inserted? **Yes / No**
If yes, when:_____ Physician Name:_____

Please check if your child has had any of the following:

- ☐ High fever
- ☐ RSV
- ☐ CMV
- ☐ TB
- ☐ Allergies
- ☐ Meningitis
- ☐ Removal of tonsils and/or adenoids
- ☐ Measles/Mumps/Rubella
- ☐ Diagnosis of a Syndrome
- ☐ Vision problems
- ☐ Epilepsy/Seizures
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Adopted/Foster Child- History unknown
- ☐ Fetal Alcohol Syndrome
- ☐ Head trauma
- ☐ Neurological problems
- ☐ Other _____

SPEECH/LANGUAGE DEVELOPMENT HISTORY:
Has your child ever received speech therapy? **Yes / No**
If yes, for how long?_____ Where:_____

If they are currently receiving speech therapy, are they progressing? **Yes /No / Not sure**

Is your child currently receiving services through Early Childhood Intervention (ECI)? **Yes / No**

Approximately how many words are in your child's vocabulary?_____

Do you have concerns for your child's speech/language development? If yes, explain:
_____

Is more than one language spoken with your child? **Yes / No**

EDUCATIONAL INFORMATION:
Grade:_____ School:_____

Does your child have difficulty in school? If yes, please explain:_____
_____

Is your child receiving any special education services? If yes, explain:_____
_____

504 Accommodations? Please list services:_____

Special education or IEP? Please list services:_____

_____ _____ _____

Parent/Guardian Signature **Relationship to patient** **Date**

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Patient Demographics

Today's Date: **MR#:**

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Age:**	**Gender:**
Phone 1:	**Phone 1 Type:** Home/Cell/Work	
Phone 2:	**Phone 2 Type:** Home/Cell/Work	
Phone 3:	**Phone 3 Type:** Home/Cell/Work	
Mailing Address:	**City/State/Zip:**	
Email:	**I prefer contact by:** Home/Cell/Email	
Name of Parent or Guardian (if patient younger than 18):		
Name of Person responsible for payment (if different from parent):		
Emergency Contact:	**Relationship:**	**Phone:**
Primary Insurance:		
Secondary Insurance:		
Name of Insured:	**DOB:**	
Current Medications (List medications plus dosage, frequency and how administered; or provide list to copy):		
Are you allergic to Latex? Yes / No		
Are you allergic to any medications? Yes / No If yes, please list:		
Referring Physician:	**Dr. Phone #:**	
Primary Care Physician:	**Dr. Phone #:**	
Do you currently have an Advance Directive or Out of Hospital DNR? Yes / No		

I hereby authorize the release of medical information to referring doctor and/or any doctor to whom my audiologist may refer me. I authorize my family or referring doctor to release my records to West Texas Rehab Center Hearing and Balance Department. I authorize the release of medical information necessary to process insurance claims and request payments of insurance benefits be made to West Texas Rehab Center Hearing and Balance Department. I hereby affirm that all information provided by me is true to the best of my knowledge, and will accept financial responsibility for my account with West Texas Rehab Center Hearing and Balance Department.

Signature:	**Date:**
Relationship to Patient:	

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HIPAA

Consent For Treatment
I,the undersigned,an thepatient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarilyconsent to and authorize West Texas Rehabilitation Center, Inc,. (WTRC), and Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.

Assignment of Benefits and Authorization of Release of Information
Iherebyassign to WTRCall benefitsprovided under anyhealthcare plan,medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I ampersonally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this assignment shallbe considered as effective and valid as the original.

I also authorize thereleaseofanyrecords/information, including papers, forms, videos, photographs and other medical entity, or attorneyinvolvedinthecase.

Payment Policies
1.Although you maybeassistedbyprivate insurance, Worker's Compensation, Medicare, Medicaid or even WTRC's Donor

Sponsorship Programpaymentforservices received by you or your family is ultimately your responsibility. Cash, personal checks and majorcreditcardsanddebit cards are accepted.
2.Payment is requiredatthetimeofservice i you have insurance plan that dictates a per visit co-payment. Patient who do not have such a featureintheirinsurance coverage will be mailed a statement indicating their financial responsibility for the services provided.
3.WTRC is committedtoassistingfamilies with their financial responsibilities. The Donor Sponsorship Program is designed to identify familieswithvariouslevelsof need and provide them with corresponding assistance. Our staff will be glad to assist you in determiningyoureligibility for assistance. Before that process can begin, however, we need to know that you would like you seekassistanceandare willing to provide the needed information.

Third Party Disclosures

I, the patient (orguardian,Healthcare Power of Attorney, or the patient's duly authorized representative) and give the following person(s) or representative(s) permission to discuss appointments, medical treatments and/or any financial matters on my behalf.

Printed Name:	**Relation:**	**Phone:**
Printed Name:	**Relation:**	**Phone:**

___ Yes ___ No I grant permission for WTRC personnel to leave messages on my home voicemail and/or cell phone.
___ Yes ___ No I grant permission for WTRC personnel to leave messages on my work voicemail and/or cell phone.
___ Yes ___ No I wish to receive emails from West Texas Rehabilitation Center.
___ Yes ___ No I grant permission for WTRC personnel to contact me for fundraising efforts.

WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask that Admissions staff.

I have been offered a copy of "Your Information. Your Rights. Our Responsibilities.", which describes how medical information about you may be used and disclosed and how you can get access to this information. If after viewing the document, should you have any questions, our Admissions staff would be glad to answer them.

Signature of Patient or Guardian:_____**Date:**_____