AUDIOLOGY ASSOCIATES OF WESTCHESTER™

550 Mamaroneck Ave. 4th Fl. Suite 407
Harrison, NY 10528

325 NY-100
Somers, NY 10589

Welcome to Audiology Associates of Westchester!

Our mission is to provide you with the best possible hearing healthcare services. It is our goal that every time you come to see us, you are satisfied with your experience and pleased that you chose the Audiology Associates of Westchester for your hearing healthcare needs.

____**Harrison** office at 550 Mamaroneck Avenue, Suite 407 (4th floor). There is parking all around the building and handicap accessible entrance in the back of the building.

_____**Somers** office at 325 NY 100. This is in the Towne Center located next to the post office. There is parking all throughout the Town Center.

Preparing for your appointment:

There are four forms in this packet to complete and bring with you or email ahead of time.

1 - Registration Form 2 - Hearing History 3 - Medications 4 - HIPAA Consent Form

- Prior Hearing Evaluations: If you have copies of prior tests, please bring them with you.
- Insurance Cards: To determine if you have a benefit for hearing tests, hearing devices, or other audiology services, please bring your insurance cards with you.
- Insurance referral if you have an HMO plan that requires one for you to see a Specialist.
- If you are coming in for a hearing device consultation, we recommend you bring a family member or friend, as it is helpful to have someone close to you involved in the hearing care process.

Physician Referral: If you are required to obtain a referral by your physician, please bring an electronic or written referral on your appointment date.

Payment Policy: We request payment at the time of service. For hearing devices, a deposit of 50% of the total cost is due when hearing devices are ordered.

Insurance Billing: If we are participating in your plan, we will file a claim to your insurance company according to the benefits outlined in your plan. The benefit quoted to us may not be the actual amount paid. If we are not participating in your plan & you choose to see our providers, payment, in full, is expected at the time of service.

Thank you for scheduling with us. We look forward to seeing you!

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PEDIATRIC BACKGROUND INFORMATION

Appt. Date: _____

Child's Name:_____ Birth Date:_____Age:_____

Parents' Names: Mother:_____ Father:_____

Siblings (sex and age):_____

Referred by: _____ Child's Physician:_____

Why are you bringing your child to see us?_____

_____

Do you think your child has a hearing problem? _____ If yes, please explain_____

_____

How does your child function in a playgroup, preschool, or school environment? Are there any social or learning issues you or your child's teacher are concerned about?_____

_____

Is your child in an early intervention program? If yes, Where? What therapy? How often?

_____

_____

Please list support services your child is receiving, if any:_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

Allergies:_____

Ear Infections:_____ If yes a) Treatment_____

b) Approximately how many per year_____

_____

c) Approximate date of last ear infection_____

_____

Myringotomy and/or ventilating tubes_____ Date:_____ Which ear?_____

High fevers_____ If yes, explain_____

Frequent colds_____ Serious illnesses_____

Is there a history of hearing loss in either parent's family?_____

Has your child ever been examined by any of the following? If so, when and why?

Ear, Nose and Throat Physician_____

Neurologist_____

Audiologist_____

Speech and Language Pathologist_____

BIRTH HISTORY:

Was pregnancy with this child full term?_____

Did mother have any illnesses during pregnancy?_____

Please list medications taken during pregnancy:_____

Other Complications? _____

Were there any complications with birth or delivery?_____

DEVELOPMENTAL MILESTONES:

At what age did the child do the following? (give approximate age)

Held head up_____Sat alone_____ Rolled over_____Crawled_____

Walked independently_____

Do you feel the child's coordination is the same as other children his/her age?_____

SPEECH AND HEARING HISTORY:

As a baby, did the child respond to sounds even when he/she could not see the source of the sound?____

Respond to speech?_____ Startle to loud sounds?_____

Did your child babble and coo as much as most babies?_____Did he/she cry excessively? _____

Was the child a very quiet baby?_____

Does your child consistently respond to sound and speech now?_____

Do loud sounds appear to really bother your child? _ _____

Does your child appear to have an ear preference?_____ Which one?_____

How old was the child when he/she began to say words?_____ When he/she began to put 2 or 3 words together in a phrase?_____ When he/she began to use complete sentences?_____

Did he/she acquire speech and then stop talking?_____

Does the child engage in conversation?_____

Does the child use gestures to express needs and wants?_____

Does the child use language to express needs and wants?_____ How often?_____

Do parents understand his/her speech?_____ Do other adults understand him/her? _____

Do playmates tease the child about his/her speech?_____

Is the child's voice too soft? ____ Too loud?____ Hoarse?____ Nasal?____

Have parents done anything to help the child with speech/language?_____ Explain:_____

_____

Is the child's vocabulary similar to other children his/her age?_____

PLEASE WRITE ANY OTHER ADDITIONAL INFORMATION YOU FEEL WOULD BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD _____