HSDC
Hearing, Speech & Deaf Center

PEDIATRIC ENROLLMENT & CONTACT FORM

Child's Name ______________________________ Today's Date ______________

Date of Birth ______________ Primary Language ______________________

Other Language(s) ______________________________

CONTACTS

Parent/Guardian/Primary Contact

Name ______________________________ Relation to Client ______________________

(please check) ☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Language(s) ______________________

Home Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ VRS

Cell Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ Video

Home Address ______________________________ Email ______________________

Parent/Guardian/Secondary Contact

Name ______________________________ Relation to Client ______________________

(please check) ☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Language(s) ______________________

Home Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ VRS

Cell Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ Video

Home Address ______________________________ Email ______________________

OTHER AUTHORIZED CONTACT

Name ______________________________ Relation to Client ______________________

(please check) ☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Language(s) ______________________

Home Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ VRS

Cell Phone ______________________ *(please check)* ☐ Voice ☐ Text ☐ Video

Home Address ______________________________ Email ______________________

Is it OK to leave voicemail containing confidential healthcare information with the numbers provided? ☐ Yes ☐ No

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PEDIATRIC HISTORY FORM

Child's Name____ Today's Date ________________

Date of Birth______________________ Sex/Gender ________________ Pronouns _____________

Person Filling out Form ___________________Relationship to Child _________________________

I. Describe any major concern(s) about your child: ______________________________________

II. What specific questions would you like to have answered: ____________________________

III. Prenatal and Birth History:

1. During this pregnancy, did the mother experience any unusual illness, accident or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please describe: ____

2. During the pregnancy did the mother (*please check)*

   ☐ Drink alcohol? ☐ Smoke?
   ☐ Take medication? ☐ Take recreational drugs?

   Please describe:____

3. Were there any complications with delivery? ☐ Yes ☐ No

   Please describe: ____

   Birth weight:_______How many weeks gestation at time of delivery: ________________

4. Condition of baby at birth (bruised, jaundiced, difficulty breathing, etc.): _______________

   Color good? ☐ Yes ☐ No Breathed easily? ☐ Yes ☐ No

   Incubated? ☐ Yes ☐ No Spent time in NICU? ☐ Yes ☐ No

   If yes, please describe length and reason of stay in Neonatal Intensive Care Unit (NICU): ____

____

IV. Feeding History

1. Any feeding difficulties immediately after birth? ☐ Yes ☐ No
   If yes, what kind?____

   My child was: ☐ Breast fed ☐ Bottle fed ☐ Both

2. Current feeding abilities (types of food/liquid and how often): ____________________

   ____

   Has your child ever gained/lost weight that was considered atypical? ______________

   Does your child need special spoons or cups? ☐ Yes ☐ No

   My child has difficulty with (check all that apply): ☐ Chewing ☐ Swallowing

   My child dislikes certain foods: ☐ Yes ☐ No Examples: ____________________

V. Development

1. **At what age did the child:**
   Wean from breast____________Wean from bottle: ______Stop using pacifier:__________
   Spoon feed:____________Drink from open cup: _________Feed self: _________
   Drink from straw: ____________
   Sit independently: ___________First crawl: _______Walk Independently: __________
   Gain bladder control:________Gain bowel control:____________

2. **Describe your child's:**
   Overall development: ____
   Coordination and balance: ____
   Self-help skills (dressing, washing, etc.): ______________________________
   Fine motor skills (using scissors, coloring, writing, etc.): ____________________
   Handedness: ☐ Right ☐ Left ☐ Undetermined ☐ Ambidextrous

VI. Medical History

1. **General**
   Does your child have frequent colds? ☐ Yes ☐ No
   History of fevers? ☐ Yes ☐ No
   History of seasonal allergies? ☐ Yes ☐ No
   History of ear infections? ☐ Yes ☐ No
   Most recent ear infection: ____________ How was it treated? ________________
   Other medical conditions or diagnoses: ____________________________________

   ____
   Is the child in good health at this time?☐ Yes ☐ No, Explain: _______________

When was your child's most recent physical examination?_______________

Physician: _______________Clinic/Hospital:_______________

Current medications: _______________

Please list all allergies: _______________

Please list all illnesses, accidents, and operations:

DATE	AGE	TYPE	DURATION	SEVERITY	HOSPITAL

2. Hearing

Does the child have a suspected or known hearing loss? ☐ Yes ☐ No

Does anyone in the child's biological family have a hearing loss? ☐ Yes ☐ No

Please list: _______________

Has your child had a hearing test before? ☐ Yes ☐ No

If yes, where? _______________When? _______________

What were the results? _______________

Does your child wear hearing aids? ☐ Yes ☐ No If yes, for how long?_______________

Has your child seen a physician for an ear examination? ☐ Yes ☐ No

When? _______________Results:_______________

Physician: _______________Clinic/Hospital:_______________

VII. Social/Education History

1. Social History

My child prefers to play (check all that apply):

☐ Alone ☐ With Others ☐ With Adults

☐ With Older Children ☐ With Younger children

Does your child have tantrums frequently? ☐ Yes ☐ No If so, how often?___________

What are some of your child's favorite activities?_______________

What types of activities/interactions does your child least enjoy?_______________

How would you describe your child's personality?_______________

2. Educational History

My child is now enrolled in (check all that apply):

☐ School ☐ Preschool ☐ Daycare ☐ None

Name of Daycare:_______________Hours and days per week:_______________

Name of School/Preschool: _______________District: _______________

Teacher's Name: _______________Grade:_______________

Speech Pathologist: _______________

Strengths in school: _______________

Areas of difficulty: _______________

Special therapies or services in school:_______________

VIII. Speech/Language

1. History

Do you have any family history of speech/language delays or disorders? ☐ Yes ☐ No

If yes, please specify: ___________________________

At what age did your child do the following?

Begin to babble:_______________ Say first word: _______________

Put words together:_______________ Use short sentences: _______________

Examples: ___________________________

____

2. Current Speech/Language Abilities

Can you usually understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Can others understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Is your child aware of her/his speech difference? ☐ Yes ☐ No

Does your child:

Readily imitate sounds, words, and/or sentences you say? ☐ Yes ☐ No

Respond to her/his name? ☐ Yes ☐ No

Point to pictures that you name? ☐ Yes ☐ No

Follow directions? ☐ Yes ☐ No

Ask/answer questions? ☐ Yes ☐ No

Relate events to you? ☐ Yes ☐ No

Understand more than s/he says? ☐ Yes ☐ No

Appear frustrated if s/he is not understood? ☐ Yes ☐ No

If yes, how is this frustration expressed? _______________

Use sign language or other gestures to communicate? ☐ Yes ☐ No ☐ Sometimes

3. Stuttering

Does your child stutter? ☐ Yes ☐ No ☐ Sometimes

Types of stuttering (*check all that apply*) : ☐ Whole word repetitions ☐ Syllable repetitions ☐ Sound repetitions ☐ Sound prolongations ☐ Total blocking

How long has this been occurring? _______________

4. Voice

Does your child frequently have a hoarse voice or lose her/his voice? ☐ Yes ☐ No

5. Other Therapy Services

Please list all current and previous services, including evaluations, and therapy sessions.

Example: Speech pathology, physical therapist. *Please provide name, address, and date*

Dates	Age	Service Type (Speech, OT, PT):	Provider:	Location:

IX. Special Health Considerations/Precautions

Please describe any special precautions or procedures we may need to know in case of emergency: ___________________________

____

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MEDICAL INFORMATION AND CONSENT FOR MEDICAL TREATMENT

MEDICAL INFORMATION

Client Name:____
Address: ____
Emergency Phone:____________________________________
Primary Care Provider:__________________________________
Health Insurance:____________________________________
Medications:____
Allergies:____
Other Relevant Medical Information: ____________________________

EMERGENCY CONTACT PERSON

Person who will be nearby or most reachable in the event of an emergency.

Name:______________________ Relation to Client: ______________
Phone:______________________ Language:__________________
Email Address:____________________

CONSENT FOR MEDICAL TREATMENT

I hereby appoint the staff of HSDC to act on my behalf in authorizing or providing emergency treatment to include: first aid and CPR; contacting 9-1-1; diagnostic procedures; medical, surgical, and hospital care; or treatment procedures to be performed for myself or my dependent by a licensed physician, hospital, or emergency personnel when deemed necessary and advisable by the physician to safeguard my or my dependent's health. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment. I also give permission for myself or my dependent to be transported by ambulance or aid car to an emergency center for treatment. I do not hold Hearing, Speech & Deaf Center responsible for any emergency treatment that may be administered. I acknowledge that I am responsible for all charges in connection with care and treatment. This consent is effective for the duration of my or my dependent's plan of care.

____________________________ __________
Printed name of client or personal representative Date

____________________________ __________
Signature of client or personal representative* Date
* Required if client is younger than 18 years of age at time of first appointment

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Hearing, Speech & Deaf Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: ______________________________ Date of Birth: ________________
Today's Date: ________________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your individually identifiable health information without your authorization, except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

I Authorize the Release Of:

☐ **ALL** my health information maintained ☐ Include Previous Provider Records

☐ My health information relating to the following treatment or condition:
____

☐ My health information for the date(s): ____________ ☐Other: ________________

Reason For Release (must be noted): ______________________________________

Send/Release Medical Records To:

Name: ______________________________ Name: ______________________________
Phone: ______________________________ Phone: ______________________________
Address: ______________________________ Address: ______________________________
Fax: ______________________________ Fax: ______________________________

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: ☐Alcohol/Drug ☐Behavior/Mental Health/Psychiatric ☐Sexually Transmitted Disease ☐HIV/AIDS ☐Other; specify exclusion ________________

I understand that I have the right to request that a service for which I have paid out-of-pocket, not be disclosed to my health plan.

This Authorization is Effective: **Date** **through** (dates must be specified)

______________________________ ______________________________
Printed name of client or personal representative Signature of client or personal representative*

**Required if client is younger than 18 years of age at time of first appointment*

REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form, my medical (healthcare) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released. I understand that I may revoke this authorization at any time by notifying the organization in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

HSDC Seattle Artz Communication Center 1625 19th Avenue Seattle, WA 98122
(206) 323–5770 | Toll-Free: (888) 222–5036 | Videophone: (206) 452–7953

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POLICIES AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT

Client Name: ______________________________ Date of Birth: ____________
Today's Date: ______________

GENERAL CLINIC PROCEDURES & ATTENDANC POLICY
_____ *(please initial)* I acknowledge that I have read and understand the general clinic procedures and attendance policy.

FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT
_____ I acknowledge that I have read and consent to the financial responsibility disclosure statement.

NOTICE OF PRIVACY PRACTICES
_____ I acknowledge that I received a copy of Hearing, Speech & Deaf Center's Notice of Privacy Practices. The Notice provides information about how HSDC may use and disclose the medical information that we maintain about you. HSDC encourages you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website, and that any revised Notice of Privacy Practices will be made available.

CONSENT TO THE USE OF VIRTUAL/REMOTE SERVICES
_____ I have read and understand the information provided regarding virtual/remote services in the *General Clinic Procedures* document. I hereby consent to and authorize HSDC to use distance technology to provide virtual or remote services to supplement the in-person services provided by HSDC.

PHOTO/PUBLICATIONS RELEASE
_____ I give HSDC or its legal representatives the absolute right and permission to include my name in articles, and to copyright and/or publish photographic portraits, pictures, or videos of me, and to use my photo in conjunction with a fictitious name for art, health, education, marketing, or any other lawful purpose. I waive my right to inspect and/or approve the finished product or the use to which it may be applied. I release, discharge, and agree to hold harmless HSDC or its legal representatives from any liability by virtue of any blurring, alteration, optical illusion, or use in composite form whether intention or otherwise, that may occur or be produced in the taking of said pictures or any processing tending towards the completion of the product.

My signature below, indicates that I have read, understand, and agree with the items I initialed above.

______________________________ ______________________________
Printed name of client or personal representative   Signature of client or personal representative*
**Required if client is younger than 18 years of age at time of first appointment*