COLUMBINE CHILD NEW PATIENT FORM

Date: ______________________________ Age: ______

Patient: ______________________________ Sex: M / F

Address: ______________________________ City: __________ State:______ Zip:_________

Phone: ______________________________ Birthday:____________________

Guarantor: ______________________________

Insurance: ______________________________ Policy #: _____________ Group #: ________

Address: ______________________________ Family Doctor/PCP: _____________________

Referral Source: ______________________________

	NO	YES	Additional Information
1. Has your child had ear infections? How Many?	____	____	___________________
2. Has your child had drainage from the ears?	____	____	___________________
3. Has your child been treated with antibiotics?	____	____	___________________
4. Has your child been treated with antihistamines?	____	____	___________________
5. Have you noticed a hearing loss in your child?	____	____	___________________
6. Has she/he failed a school hearing test?	____	____	___________________
7. Has your doctor commented that he/she has Had fluid in her/his ears?	____	____	___________________
8. Has she/he had more than 2 episodes of Tonsillitis in the past year?	____	____	____________________
9. Is she/he missing school? How many days?	____	____	____________________
10. Does she/he mouth breath at night?	____	____	____________________
11. Have you been told or do you suspect that Your child might have allergies?	____	____	____________________
12. Is she/he taking medication at this time?	____	____	____________________
13. Is she/he allergic to any medication?	____	____	____________________
14. Has she/he every had surgery or been admitted To the hospital?	____	____	____________________
15. Does she/he or any relatives have a history of Of bleeding problems?	____	____	____________________

Please list any serious illnesses/surgeries that the child has had: _________________________________

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The responsibility for the bill is between the patient and the office. It is our policy that the patient pay charges at the time of service. Insurance forms are filed as a courtesy to our patients. Benefits are assigned. I authorize payment of benefits to Terry Cummings, Au.D. for services rendered. I do hereby understand the above and voluntarily consent to diagnostic procedures and services rendered.

Signature: ____