



Hearing Solutions of Louisiana, LLC
1327 Stelly Lane, Suite C, Sulphur, LA 70663 (337) 528-7842

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: Male or Female Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance _____ Policy & Group# _____

Name & Date of Birth of Policy Holder _____

Secondary Insurance _____ Policy & Group # _____

Name & Date of Birth of Policy Holder _____

Spouse or Responsible Party _____ SS# _____ Date of Birth _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Email Address: _____

Nearest Relative NOT Living at Same Address _____ Relation _____

Home Telephone _____ Alternate Telephone (Cell) _____

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE CLAIMS AND RELEASE OF MEDICAL RECORDS IS HEREBY GIVEN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature

Date

Pediatrician: _____

Who may we thank for referring you? _____

Reason for visit today: _____

Who may we discuss your results with? _____

Information About Your Child

Any problems during pregnancy or birth? _____

If so, please describe below.

Did the baby require any oxygen or a NICU stay? _____

Did the mother take any medications during pregnancy? _____

Is there a family history of hearing loss? _____

Did your child pass his/her newborn hearing screening? _____

Does your child respond to your voice? _____

Is your child talking louder than usual? _____

Is the TV louder than usual? _____

Is your child having any problems in school do to hearing? _____

Has your child had an ear infection? _____ How many? _____

Has your child had ear tubes? _____ Has your child ever had ear surgery? _____

Has your child ever been diagnosed with a disease or syndrome? _____

Has your child had any recent illness? _____