LEXINGTON
HEARING AND SPEECH CENTER, INC.

25-26 75th Street, East Elmhurst, N.Y. 11370
(718) 350-3171 ♦ (718) 458-1367 (FAX)

CHILD INTAKE FORM

TODAY'S DATE: _____/_____/_____

PATIENT INFORMATION/ INFORMACION DEL PACIENTE						
Last name / *Apellido*	**First /** *Nombre*	**M.**	**Sex: Male/Female** *Sexo: F / M*		**DOB:** *Fecha de Nacimiento*	
Street Address: *Direccion*					**Home Phone No.:** *Telefono*	
City: *Ciudad*	**State:** *Estado*	**ZIP Code:** *Zona Postal*			**Language:** *Idioma:*	
Mother's Name *Nombre de la Madre*		**Father's Name** *Nombre del Padre*				
Who referred you to this clinic? *Referido a la clinica por: (porfavor indique por quien)*	☐ Doctor	☐ Hospital	☐ Family	☐ Friend	☐ Agency/School	☐ other
Name and Contact of Referring Provider:						
Reason for Referral: *Cual es la razon de esta visita?*						
Primary Doctor's Name/Address/Telephone No.						

INSURANCE INFORMATION/INFORMACION DEL SEGURO MEDICO (REQUIRED INFORMATION)		
(Please give your Insurance card to the receptionist.) *Porfavor de su tarjeta del seguro al recepcionista*		
Primary Insurance Name:		
Policy Holder Name:	**Relationship to Policy Holder:**	Self / Spouse / Child / Other
Policy Holder Date of Birth:		
Policy Holder Social Security No.:		
Medicaid #	**Private Ins.#**	**Other Insurance #**

MEDICAL HISTORY STATUS / HISTORIAL MEDICO	
Did the mother take any medications during the pregnancy? If so please state reason? *Que medicinas tomo la madre durante el embarazo y por que?*	
How long was the pregnancy? *Cuanto tiempo duro el embarazo?*	**What hospital was the baby born?** *Que hospital nacio el bebe?*
How long was the actual birth? *Cuanto tiempo duro el parto?*	**How was the baby born?** *Como nacio el bebe? C-seccion o Natural*
How much did the baby weigh? *Cuantas libras peso el bebe?*	**How long did the baby stay in the hospital? And the mother** *Cuanto permanecio el bebe en el hospital? Y la mama?*
Were there any surgical instruments used during the delivery? *Se utilizo algun instrumento medico durante el nacimiento?*	
Were any medications given to you during the delivery? *Se administraron medicamentos durante el parto?*	
Was the baby born healthy? *Nacio el bebe saludable?*	
Was the baby born jaundiced? *Nacio el bebe Amarillo?*	
Was the baby born with respiratory problems? *Nacio el bebe con problemas respiatorios?*	
Did the baby require supplemental oxygen at birth? *Necesito el bebe oxigeno al nacer?*	
Did the baby need antibiotics or any other medicines? If so please list them. *Necesito el bebe antibioticos y otras medicinas al nacer? Si ese es el caso listelos por favor.*	
Did the baby require any other procedure shortly after the birth? *Que otro procedimiento el bebe necesito al nacer o poco despues de su nacimiento*	

Turn over

Please describe any delays the child has or had with eating, sleeping, sitting, crawling, speech, hearing, or vision?
Describe cualquier atraso o problemas que el bebe tiene o ha tenido para comer, dormir, sentarse, gatear, hablar, oir, y ver?

Has the baby been hospitalized since birth? If yes, please indicate when, where, and why and what procedures and medications were given? *El bebe has estado hospitalizado despues que nacio? De contestar si, por favor indique donde, cuando, por que y cualquier procedimiento o medicamento que se la administro.*

AT WHAT AGE DID YOUR BABY: *A QUE EDAD SU BEBE:*	
Sit up alone: Se sento sin ayuda	**Said his/her first word** Dijo sus primeras palabras
Crawled Gatio	**Said his/her first sentence** Dijo su primera oracion:
Walked Camino	

How does your child communicate with you when he/she wants things? *Como el nino(a) se comunica con usted cuando necesita algo?*

PLEASE INDICATE IFYOUR CHILD HAS OR HAD ANY OF THE FOLLOWING (*POR FAVOR INDIQUE SI SU NINO (A) TIENEN LO SIGUENTES)*			
Allergies Alergias	**Encephalitis** Encefalitis	**Heart Problems** Problemas del corazon	**Scarlet Fever** Escarlatina
Asthma Asma	**Epilepsy** Epilepsia	**Kidney Problems** Problemas de rinones	**Head Injuries** Fracturas o golpes de cabeza
Chicken Pox Viruela	**Vision Problems** Problemas de Vision	**Meningitis** Meningitis	**Other:** Otra
Seizures Ataques	**Sleep Apnea** Suspension transitoria de la respiracion	**Ear Infections** Frequentes infecciones de oido	
Measles Sarampion	**Frequent colds** resfriados frequentes	**Mumps** Paperas	

PLEASE INDICATE IF CHILD HAS RECEIVED ANY OF THE FOLLOWING EVALUATIONS OR THERAPY. IF SO WHEN AND WHERE. *(POR FAVOR INDIQUE SI SU NINO (A) A RECIBIDO EVALUACIONES OR TERAPIA)*	
Speech /*Lenguaje*	**Hearing/** *Audicion*
Psychological/ *Psicologico*	**Neurological/** *Neurologica*
Physical / *Fisica*	**Occupational** *Ocupacional*
Educational/ *Educativa*	**Other/** *Otra*

Please describe the child's behavior with other children? And at home? *Por Favor describa la conducta del nino (a) con otros ninos?*

Are there any children in the family with hearing and/or speech problems? If yes, please state age and medical history.
Hay en su familia ninos con problemas de language o auditivo? Si es cierto, por favor indique edad y historia medica.

Who does the child stay with most of the day and what language do they speak? *Con quien permanence el nino(a) la mayor parte del dia? Y que idioma hablan?*

Please indicate any other concerns *(Indique por favor cualquier si tiene otra preocupacion.)*

Audiologist Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Parental Consent for Evaluation

Child's Name: _____

Date of Birth: _____

Date: _____

I authorize the assessment of my child by the Lexington Hearing and Speech Center for a hearing test and / or Speech and Language evaluation / developmental evaluation and Social History Interview as part of the evaluation process.

I have been informed that this evaluation may include listening tasks, play activities, or tests that do not require my son or daughter's direct participation. I will be included in these tests as a participant or observer. All test results will be explained and a copy of the final evaluation will be sent to me.

_____
Signature of Parent or Guardian

_____
Print Name of Parent or Guardian

_____
Relationship

_____
Evaluator

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Date:_____

For the purposes of coordinating your healthcare, Lexington asks that you indicate with whom we may share your audiological records. We do strongly suggest that you share your audiology report with your primary care physician.

I hereby give my permission to the Lexington Hearing and Speech Center to obtain or release a copy of the following records to those persons/agencies I have designated below.

___Educational ___Audiological __Speech/Language Pathology
___Hearing Aid __Otolaryngology

Patient Name:_____

Date of Birth:_____

Signature:_____

Print Name:_____

Relationship:_____

I know that this release is valid for one year from the above date.

Name	**Address including Zip Code Room/Apt No.**
1) _____ *Primary Care Physician*	_____
	_____
2) _____	_____
	_____

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NOTICE OF PRIVACY PRACTICE PATIENT ACKNOWLEDGEMENT

I, hereby state that I have received the above Notice of the Privacy Practices of Lexington Hearing and Speech Center

_____

Name of Patient

_____/_____/_____

Signature Date Received

_____

Signature of Patient Representative Relationship to Patient

I, hereby state that I have received, read, and understand The Notice of Privacy Practices of Lexington Hearing and Speech Center. I have certain rights to privacy in regards to my protected health information (PHI). As such, I give consent to Lexington Hearing and Speech Center to use or share my health information for the purpose of treating me, obtaining payment for that treatment, and running the business operations for their practice.

_____

Name of Patient

_____/_____/_____

Signature Date Received

_____

Signature of Patient Representative Relationship to Patient

The patient was given the Notice of Privacy Practices of Lexington Hearing and Speech Center, and refused to sign

_____

Employee Name (please print)

_____/_____/_____

Employee Signature Date Received
