Pacific Northwest Audiology

Pediatric Patient Information

Date _____ File# _____

Patient Name _____ Preferred Name _____
Last First M.I.

D.O.B. _____ Male ☐ Female ☐ Live with _____

Parent / Caregiver Name / Relation _____

Mailing Address _____
Street City State Zip Code

Preferred Contact Phone: _____ (Cell) _____(Home) _____(Work)

Email Address _____

Permission to Communicate via Email (Medical Reports, Invoices, Appointments) Yes ☐ No ☐

Permission to Communicate via Email (Educational Seminars and Events) Yes ☐ No ☐

Referred By _____

Primary Care Physician & Clinic _____Phone _____

Permission to Send Medical Records / Reports to Your Physician Yes ☐ No ☐

Day Care Center / School / District and Contact _____

Phone _____ Email _____

Individualized Educational Plan (IEP) / 504 Plan _____

Emergency Contact _____Relationship to Patient _____

Phone _____ Email _____

Insurance _____ ID# _____ Phone _____

Subscriber _____ D.O.B._____ Relation _____

Supplemental / Secondary Insurance _____ Phone _____

Acknowledgement of Receipt of the Notice of Privacy Practices Yes ☐ No ☐

Acknowledgement, Consent & Authorization

I hereby authorize Pacific Northwest Audiology LLC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Pacific Northwest Audiology and I am financially responsible for any unpaid balance.

Signature of Patient or Guardian _____ **Date** _____

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