THE CHILDREN'S COCHLEAR IMPLANT CENTER AT UNC
5501 Fortunes Ridge Drive, Suite A
Durham, NC 27713
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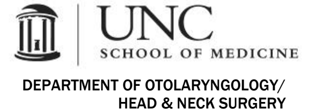

NEW PATIENT FORM

Please fill out this form as completely as possible.

Demographics

Child's Name: ______________________ Today's Date: ______________

Date of Birth: ____________ Gender ☐ M ☐ F Age: ____ Grade (if school age) ________

Child's UNC Medical Record #: ______________________

Mother's Name : ______________________

Mother's DOB: ____________ Mother's Daytime PHONE: ______________________

Mother's EMAIL: ______________________

Mother's Education Level: ☐ Some HS ☐ HS ☐ Some College ☐ BA/BS ☐ Post-Grad. Degree

Father's Name: ______________________

Father's DOB: ____________ Father's Daytime PHONE: ______________________

Father's EMAIL: ______________________

Father's Education Level: ☐ Some HS ☐ HS ☐ Some College ☐ BA/BS ☐ Post-Grad. Degree

Who does the child live with? ______________________

Physical Address: ______________________

City ______________________ State ____________ Zip ____________

Primary language in the home: ______________________

Siblings (names and ages): ______________ ______________

______________ ______________

Hearing Loss History

Did your child pass his or her newborn hearing screening? ☐ Yes ☐ No

If there was no hearing loss at birth, when did your child lose hearing? ______________

Age at first diagnosis of hearing loss: ____________ Age of first hearing aid fit: ____________

Hearing loss is: ☐ Progressive ☐ Stable ☐ Fluctuating

Etiology (cause): ______________________

Left Ear Degree of Hearing Loss: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Right Ear Degree of Hearing Loss: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Parents Childhood Hearing (Check one):

☐ Neither parent has hearing loss ☐ Both parents have hearing loss

☐ Mother has hearing loss ☐ Father has hearing loss

How often does your child wear the hearing aids or CI? ______________________

If your child currently has a CI, please fill out the following:

	Left Ear	Right Ear
Device:		
Surgery Date:		
Surgeon and Clinic:		
Most Recent Audiologist:		

Communication History

Is the child currently getting any speech therapy? ☐ Yes ☐ No

If so, how often is therapy? ______

Any history of speech/language problems in family? ☐ Yes ☐ No

Current Mode of Communication: ☐ TC ☐ Sign ☐ Cue ☐ Spoken

How many words does your child… Speak: ______ Sign: ______

How many words does your child understand? Spoken: ______ Signed: ______

How does your child communicate with you? (tell you when s/he wants or needs something, etc.)

Medical History

What was the length of the pregnancy? ______

Following the birth, did your child have:

NICU stay? ☐ yes ☐ no Oxygen? ☐ yes ☐ no

IV Antibiotics? ☐ yes ☐ no High Bilirubin? ☐ yes ☐ no

Other medical history/hospitalizations: ______

Has your child been diagnosed with another disability besides hearing loss? ☐ yes ☐ no

If so, what? ______

Are immunizations current? ☐ yes ☐ no

Please check if your child has had any of the following:

☐ Vision problems	☐ High fever	☐ Seizures
☐ Surgery	☐ Frequent colds	☐ Ear infections
☐ Ear tubes	☐ Measles	☐ Feeding tube
☐ Meningitis	☐ Encephalitis	☐ Other

Anything else you would like us to know? ☐ yes ☐ no

Family Income Level

- [ ] Less than $25,000
- [ ] $25,000-$49,999
- [ ] $50,000 - $74,999
- [ ] $75, 000-$99,999
- [ ] $100,000+
- [ ] Do not wish to provide

Insurance Coverage and Billing

Company Name: ______________________________

Policy Number: ______________________________ ______________

Effective Date: ______________________________ Co-Pay: ______________

Subscriber's Name: ______________________________

Relationship to patient: ______________________ Subscriber's DOB: ______________

Family Goals

Please complete the following open ended statements so we are best able to help your family.

I hope…

I am concerned about…

I am happy about…

I need help with…

I want to talk about…

I want to learn more about…

My child is…

The Children's Cochlear Implant Center at UNC

Who is on your child's team?
Help us keep up-to-date by filling out the form below.

Today's Date: ____________________

Patient Name: ____________________ Date of Birth: ____________________
Parents' Name(s): ____________________

School System

County: ____________________

School: ____________________

Classroom Teacher: ____________________

Pediatrician

Name: ____________________

Practice Name: ____________________

School Audiologist

Name: ____________________

CDSA Coordinator (if under 3)

Name: ____________________

Other Audiologist

Name: ____________________

Beginnings Representative

Name: ____________________

Speech-Language Pathologist (School)

Name: ____________________

Early Interventionist (if under 3)

Name: ____________________

Speech-Language Pathologist (Private)

Name: ____________________

Language Facilitator

Name: ____________________

Teacher of the Hearing Impaired:

Name: ____________________

Interpreter

Name: ____________________

Others working with your child

Specialty: ____________________ Name: ____________________

Specialty: ____________________ Name: ____________________

Specialty: ____________________ Name: ____________________

Specialty: ____________________ Name: ____________________