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"Please print clearly"

BERRIEN COUNTY HEARING IMPAIRED PROGRAM
HEARING CENTER – AUDIOLOGY

revised 03-27-18

DATE: _____ COUNTY: _____

NAME: _____ AGE: _____ BIRTHDATE: _____

#1
Parent/Guardian: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Home Phone: _____ Cell: _____

E-Mail : _____
Preferred method of contact: ☐ Phone ☐ E-mail

#2
Parent/Guardian: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Home Phone: _____ Cell: _____

E-Mail : _____
Preferred method of contact: ☐ Phone ☐ E-mail

Message Phone: _____ Name & Relationship to child: _____

School: _____ Grade: _____ Teacher (s): _____

Check if your child receives any of the following:

_____ Special Education Teacher(s): _____

_____ Speech Therapy Therapist: _____

_____ HI Teacher Consultant Consultant: _____

Primary Care Physician: _____

Ear, Nose & Throat Doctor: _____

Type of Insurance: _____ Medicaid What Plan: _____ Active: _____Yes _____No

_____ Children's Special Health Care Services Current: _____Yes _____No

ID #: _____

Other Type of Insurance: _____

A copy of the Audiology Report will be sent automatically to Parent/Guardian and the Referring Source.
Please list any additional requests below.

_____ _____

_____ _____