The Ear, Nose, Throat & Plastic Surgery Associates

Drs. Ho • Lehman • Kielmovitch • Baylor • Tipirneni • Spector • Patni • Tran • Kang • Jadidian • Johnson

PA-C: Jeff Fichera • Jessica Curley • Farida Hussain • Rebecca Korman • Jeffery Wilson

Date:_____ **PLEASE PRINT LEGIBLY** Chart # _____

PATIENT INFORMATION

Legal Name: Mr. Mrs. Ms._____
(Circle One) (Last) (First) (Middle)

Address:_____
(Street) (Apt. #) (City) (State) (Zip + 4)

Mailing Address:_____
(if different from above) (Street) (Apt. #) (City) (State) (Zip + 4)

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

E-Mail Address: _____

Patient's Occupation:_____ ☐ Patient's Employer or ☐ School:_____

☐ Child ☐ Single ☐ Divorced ☐ Married ☐ Widow Date of Birth:_____ Age:_____ ☐ M ☐ F

Patient's Social Security #: _____ Spouse Parent Guardian (Name):_____
(Circle One) (If Guardian, please provide copy of court order)

Primary Care Physician (PCP):_____Address:_____Phone:_____

Referring Physician:_____Address:_____Phone:_____

Preferred Language (Mark Only One) ☐ English ☐ Spanish

Race: (Mark Only One) ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Decline to State

Ethnicity (Mark Only One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State

COMPLETE SECTION BELOW IF YOU ARE A PARENT/GUARDIAN OF A MINOR PATIENT

Legal Name: Mr. Mrs. Ms._____ ☐M ☐ F D.O.B._____ SS#: _____
(Circle One) (Last) (First) (Middle)

Mailing Address:_____
(Street) (Apt. #) (City) (State) (Zip + 4)

Home Phone: (____)_____ Work Phone: (_____)_____ Relationship to Patient: _____

Employer of Responsible Party: _____Name of Spouse: _____

INSURANCE COMPANY INFORMATION (*Complete and give us your card to copy.)*

Name of Primary Insurance: _____

Primary Insured's Name:_____D.O.B._____ Social Security #: _____

If insurance card is not available, please fill in the following information on your primary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone:_____Group Name or No._____I.D. No._____

Name of Secondary Insurance: _____

Primary Insured's Name:_____D.O.B._____ Social Security #: _____

If insurance card is not available, please fill in the following information on your secondary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone:_____Group Name or No._____I.D. No._____

Signatures Required on Back of Form

Signature Required in Two Places

FINANCIAL POLICY PLEASE READ

All copayments, deductibles and coinsurance amounts are due at the time services are rendered. Our office will file charges with the insurance plans in which we participate. In the event of a hospital admission and/or surgery, the office will file the charges to your insurance carrier as a courtesy. However, financial responsibility remains with the patient. Any amount not covered by the insurance carrier is due from the patient at the time of notice.

SELF PAY

Full payment is due at the time services are rendered.

MEDICARE

Our office accepts assignment on all Medicare claims. Please provide us with any additional insurance coverage you may have. If you only have Medicare, our office will collect any deductible and/or coinsurance amounts at the time of service.

PATIENT RESPONSIBILITY

All patients are responsible for knowing the requirements of their insurance plans, including which labs and radiology facilities they may use, what services are covered, etc. Our staff will assist our patients, but we cannot be responsible for knowing or interpreting the benefits of each individual policy.

PLEASE READ AND FILL OUT COMPLETELY

Please list any family members or significant others that you give your authorization for this practice to discuss any non-emergency medical/billing issues if you are not readily available. For example, if someone were to call on your behalf, they need to be listed here. ***If none, write "None".***

Name, Relationship To You and Phone Number: _____

You are responsible for notifying this practice of any changes to this list.

PLEASE READ AND SIGN THIS PATIENT CONSENT:

I hereby give my consent for any and all examinations, treatment, therapy, care, anesthetics, ear cleaning, administration of medications, and diagnostic procedures including scopes, during the course of my care. The risks and complications may include but are not limited to bleeding, infection, damage to adjacent tissues or organs, swelling, pain, anesthesia, or medication reactions.

Signature: _____ Date: _____

YOUR SIGNATURE WILL SERVE FOR ANY OR ALL OF THE FOLLOWING:

I hereby give consent to The Ear, Nose, Throat and Plastic Surgery Associates to provide the necessary treatment the assigned physician and I have discussed.

I am aware that payment is expected at the time service is rendered.

Notice of Privacy Practices: I have received the Notice of Privacy Practices.

Authorization of Medical Release: I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefits either to myself or to the party who accepts assignment.

Lifetime Signature Authorization for Medicare: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.
Insurance Authorization (applies only as stated above): I authorize payment of medical benefits to the attending physician for services described.

I permit a copy of these authorizations and assignments to be used in place of this original that is on file at the physician's office.

Signature:_____**Date**:_____

Responsible Party

Revised 11/8/18

EHR Pediatric Medical History Form

(16 years or younger)

Name: _____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Reason for Visit*:* _____

PLEASE LIST ANY MEDICATIONS CURRENTLY TAKEN

Medication Name/Dosage:	**Prescribed By:**
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies

Medication Name:	**Reaction to Medication**: Rash, Trouble Breathing, Diarrhea, Vomiting
_____	_____
_____	_____

Pre-Natal Problems or Risk Factors: ***(Please check if applicable)***

___ Genetic disorders/birth defects
___ Maternal history of rash or viral illness during the pregnancy
___ Mother over 35 years of age at conception
___ Maternal smoking or use of other tobacco products during the pregnancy
___ Maternal use of recreational drugs during the pregnancy

Delivery History:

APGAR score ___ at 5 min ___ at 10 min ___Unknown
Birth Weight: ___ pounds ___ ounces
Gestation: ____ weeks (how many weeks pregnant when child born)

Birth-Related (Perinatal) Problems: *(Please circle if applicable)*

Delayed growth and development, jaundice, premature birth, respiratory distress, septicemia.

Congenital and Hereditary Problems: *(Please circle if applicable)*

Cleft palate, congenital malformation, Down Syndrome, Other:

_____

FEEDING HISTORY: *(Please check)*

Bottle Fed as Infant ___Yes ___No
Age at last use of bottle? ____ months

Breast Fed as Infant ___Yes ___No
How long did infant breast feed? ____ months

Pacifier use ___Yes ___ No
Is pacifier still used? ___Yes ___No

EHR Pediatric Medical History Form
(16 years or younger)
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(Please circle if applicable)
Childhood Communicable Diseases: Chickenpox, Haemophilus influenza B, Strep throat
Cancer: Ewing's sarcoma, Kaposi sarcoma
Head and Face: Migraine headache
Eyes: Lazy Eye, Crossed Eye
Ears: Wax impaction, Chronic or frequent ear infections, Tympanic membrane perforation
Nose and Sinus: Chronic sinusitis, Frequent colds, Nasal allergies
Mouth and Throat: Recurrent tonsillitis, Tonsil and adenoid enlargement
Cardiovascular: Cardiomyopathy, Mitral valve prolapse, Patent ductus arteriosus, Tetralogy of Fallot
Respiratory: Asthma, Cystic fibrosis, Gastero-esophageal-tracheal reflux,
Pediatric respiratory distress syndrome, Tracheo-esophageal fistula
Gastrointestinal: Gastroesophageal reflux, Intestinal obstruction, Pyloric stenosis
Genitourinary: Kidneys and Urinary Tract: Bedwetting (enuresis), Recurrent urinary infection
Musculoskeletal: Arthritis, Rickets
Integumentary: Facial rash, Eczema
Neurologic: Seizures, Meningitis, Sleep disorder
Psychiatric: Attention Deficit & Hyperactivity Disorder (ADHD), Bulimia, Depression, Sexual abuse
Endocrine: Diabetes, Obesity, Thyroid dysfunction
Hematologic and Lymphatic: Anemia, Hemophilia
Immunologic: HIV, Mononucleosis, Severe reaction to insect sting

SURGERIES AND HOSPITALIZATIONS: Problems with Anesthesia? ___ Yes ___ No

Previous Surgery/Dates	**Previous Hospitalizations/Dates**
_____	_____
_____	_____
_____	_____
_____	_____

SERIOUS INJURIES: *(Please circle)*
Head Injury Yes No
Ear Injury Yes No
Chest Injury Yes No

TESTS AND IMMUNIZATIONS:
Immunizations: Are Immunizations up to date? ___Yes ___No
Previous Flu Shot? ___Yes ___No Most Recent Year Received: _____
If no, please provide a reason (i.e. allergy to injection, declined, etc.)_____
_____
Has previous testing been done? ___Yes ___No If Yes, please give dates: CT Scan_____
MRI Scan_____ Hearing Tests_____ Allergy Testing_____

EHR Pediatric Medical History Form

(16 years or younger)

FAMILY HISTORY: ***(Please circle or check if applicable)***

Is child adopted? ___Yes ___No
Parents' Health Status: Mother: Good Poor Age___ Father: Good Poor Age___
Problems with Anesthesia: ___Yes ___No
Ears: Hearing Loss Age____
Nose and Sinuses: Nasal Allergies
Respiratory: Asthma, Cystic Fibrosis
Neurologic: Epilepsy, Neural Tube Disorder
Psychiatric: ADD/ADHD, Substance Abuse
Endocrine: Diabetes, Thyroid Disease
Hematologic/Lymphatic: Anemia, Bruising Problems
Allergic/Immunologic: Pertinent negatives: Allergies requiring treatment, HIV/AIDS

SOCIAL HISTORY *(Please Circle)*

Caffeine use: # of caffeinated drinks/day___
Second-hand smoke exposure: ___Yes ___No
Environmental exposure to toxins or irritants: School, Home, Other:_____
Hand Dominance: Left Right Infant unspecified
Nutrition: Who prepares most meals for child? Mother, Father, Grandparent, Sibling
Home Living Situation and Relationships: Lives with Mother, Father, # of Siblings_____
Personal Handicaps, Disabilities, and Assistive or Devices: None Other: _____

REVIEW OF SYSTEMS *(Please Circle Any From the Last 6 Weeks)*

Constitutional Symptoms: Change in appetite, change in thirst, decreased energy, fever, sleeping problems, unintentional weight gain, unintentional weight loss
Eyes: Crossed eye, itchy eyes, use of corrective eyeglasses or contact lens
Ears, Nose, Mouth and Throat:
Ears: Drainage, pain
Nose and Sinuses: Nasal congestion, nosebleeds, runny nose
Mouth and Throat: Bad breath, frequent throat clearing, hoarseness or other voice change, snoring, sore throat, sores in the mouth
Cardiovascular: Bluish discoloration of lips and/or fingernails, heart murmur
Respiratory: Cough, wheezing
Gastrointestinal: Abdominal pain, change in bowel habits, painful swallowing
Genitourinary: Bedwetting
Musculoskeletal: Joint swelling, weakness
Integumentary: Easy bruising, poor wound healing
Neurological: Change in smell, change in taste, difficulty with balance, difficulty with coordination, headache
Endocrine: Excessive fatigue, urinating more than usual
Hematologic/Lymphatic: Easy bruising, neck masses
Allergic, Infectious, Immunologic: Hives, rash after contact with specific substance, severe reaction to an insect bite or sting, sneezing, recurrent swelling of the face, lips and/or tongue

PARENT SIGNATURE: _____ DATE: _____