ENT CARE for kids

Patient history

Date _____ Reason for visit _____

Patient name _____ Age _____ DOB _____

Referred by _____ Primary physician/pediatrician _____

Drug allergies _____ ☐ No known drug allergies

Current medications _____ ☐ Immunizations up to date ☐ Not up to date

In the last six months

Number of tonsillitis/strep throat _____

Number of ear infections _____

Number of nasal/sinus infections _____

Antibiotics taken in the last six months*

☐ Amoxicillin ☐ Ceftin ☐ Rocephin ☐ Other
☐ Augmentin ☐ Cefzil ☐ Suprax _____
☐ Biaxin ☐ Clindamycin ☐ Vantin
☐ Cedax ☐ Omnicef ☐ Zithromax _____

Current symptoms*

☐ Abnormal bleeding ☐ Ear drainage ☐ Hoarseness ☐ Restless sleep ☐ Tugging at ears
☐ Acid taste ☐ Ear pain ☐ Muscular weakness ☐ Ringing in ears ☐ Vomiting
☐ Awakening at night ☐ Easy bruising ☐ Nasal congestion ☐ Seizures ☐ Wheezing
☐ Bed wetting ☐ Eye drainage ☐ Nasal drainage ☐ Sleeplessness ☐ Other
☐ Cough ☐ Fever ☐ Poor appetite ☐ Snoring
☐ Developmental delays ☐ Fullness in ears ☐ Poor weight gain ☐ Sore throat _____
☐ Diarrhea ☐ Gagging on food ☐ Rash ☐ Speech Delays
☐ Dizziness ☐ Hearing loss ☐ Reflux/spitting up ☐ Stomach Ache _____

Medical history*

☐ Acid reflux ☐ Bleeding disorder ☐ Frequent infections ☐ Neurologic problems ☐ Syndrome
☐ Anesthesia problems ☐ Eye problems ☐ Heart problems ☐ Premature
☐ Asthma ☐ Food allergies ☐ Nasal allergies ☐ Other _____

Hospitalizations/other medical conditions _____

Has your child been to an allergist? ☐ No ☐ Yes If yes, whom _____

Surgical procedures ☐ Ear tubes ☐ Adenoidectomy ☐ Tonsillectomy Other _____

Family history* ☐ Anesthesia problems ☐ Asthma / allergies ☐ Bleeding disorders ☐ Hearing loss ☐ Reflux

Social history* ☐ Pacifier use ☐ Daycare School grade ____ ☐ Smoking exposure in home ☐ Tobacco use

Office use only: Ht _____ Wt _____ Temp _____ Record # _____

*Check all that apply

8325 Walnut Hill Ln. #100, Dallas, TX 75231 F: 214.696.8908 **T: 214.696.8900** entcareforkids.com

ENT CARE for kids

Patient registration

*Indicates required field

*Patient's name _____ Date _____ *Gender: Male ☐ Female ☐

*Address _____ City _____ State _____ Zip _____

*Phone numbers _____ / _____ *Email _____

*Patient SSN# (if applicable) _____ *Patient date of birth _____

Referral information (How did you hear about us?)

Doctor ☐ Friend ☐ Hospital ☐ Insurance company ☐ Internet search ☐ Other patient ☐ Relative ☐ Yellow Pages ☐

*Referred by _____ Phone _____

Primary physician/pediatrician _____ Phone _____

Parent/guardian information

*Primary contact _____ Relationship _____

*Address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____ Home phone _____

Secondary contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____ Home phone _____

Insurance information (Financial guarantor)

*Name _____ *Date of birth _____

Relationship _____ Employer _____ *Insured's SSN# _____

Primary insurance _____ Phone _____

Group # _____ Policy # _____ Are you insured by HMO? Yes ☐ No ☐

*Statement of financial responsibility

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize ENT Care for Kids to release any information necessary to process a claim for insurance benefits and authorize payment directly to the physician. *Initial _____

*Indicates required field

8325 Walnut Hill Ln. #100, Dallas, TX 75231 F: 214.696.8908 T: 214.696.8900 entcareforkids.com

ENT CARE for kids

Privacy authorization

Patient's name (please print) _____ Date of birth_____

The following are acceptable means of contacting me:

By my primary phone at _____ Is a detailed message acceptable? ☐ Yes ☐ No

By my alternate phone at_____ Is a detailed message acceptable? ☐ Yes ☐ No

By email at _____Is a detailed message acceptable? ☐ Yes ☐ No

By mail at _____Is a detailed message acceptable? ☐ Yes ☐ No

We are bound by law not to discuss your child's condition with others unless authorized by you in writing. If you wish others to be able to obtain medical information regarding your child, please list those individuals below. This authorization will remain valid until revoked by you in writing.

Name _____ Relationship_____

This individual may also obtain medical treatment for my child: ☐ Yes ☐ No

Name _____ Relationship_____

This individual may also obtain medical treatment for my child: ☐ Yes ☐ No

Name _____ Relationship_____

This individual may also obtain medical treatment for my child: ☐ Yes ☐ No

I have been offered a copy of the privacy practices for ENT Care for Kids.

_____ _____

Signature of patient, parent or legal guardian Date

8325 Walnut Hill Ln. #100, Dallas, TX 75231 F: 214.696.8908 T: 214.696.8900 entcareforkids.com

ENT CARE for kids

Consent and authorization

Consent for treatment (all fields required)

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, tests, procedures, and other care deemed necessary or advisable for the diagnosis and treatment of my or my child's medical condition. This consent is valid for each visit I make to ENT Care for Kids unless revoked by me in writing.

Patient Name (please print) _____Date of birth_____

Signature of parent or legal guardian _____ Relationship _____ Date_____

Assignment of insurance benefits

I hereby authorize payment of all surgical or medical benefits directly to ENT Care for Kids. I understand that I am financially responsible to ENT Care for Kids for charges not covered by my insurance and will be billed accordingly. If applicable, I also understand that if I do not follow the requirements as outlined in my managed care benefit plan (referral forms, authorizations, etc.), I will be financially responsible for all charges and will be billed accordingly.

Authorization for release of information

I herby authorize ENT Care for Kids to furnish medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to me or my child. I understand this information will only be furnished: **1**) to my insurer(s) to which my or my child's medical bills have been assigned for payment; **2**) as required by law; or **3**) upon my written authorization on an acceptable form or by letter. I understand that my or my child's medical information will not be released without my express written permission. I also understand that with my written permission, my or my child's entire record can be released to the healthcare provider as specified in my written request. Any revocation of this release must be submitted in writing. For the purpose of this release, "medical information" shall mean copies of all medical records, laboratory tests (including HIV or AIDS testing), radiographic examinations, reports and/or other materials in the possession of ENT Care for Kids relating to my or my child's medical condition and proposed or actual treatment. This information may also be shared with other pertinent health care providers such as you or your child's primary physician/pediatrician, or with a patient's parent(s) or legal guardian.

By signing this Consent to Release Medical Information, I agree not to hold liable ENT Care for Kids, their agents and employees, for any unfavorable outcomes as the result of releasing this information. I realize that release of my or my child's medical information may be necessary before my insurer will cover the cost of my medical treatment, and that by failing to authorize the release of this information, I may be required to pay the entire bill. I also give permission to ENT Care for Kids to release my/my child's medical information electronically, via fax or email, and release them from any and all resulting liability.

I have read and understand all of the above, and agree to the terms and stipulations therein.

Signature of parent or legal guardian _____Relationship _____ Date_____

Notice concerning complaints *Complaints about physicians, as well as other licensees and registrants such as physician assistants and acupuncturists, may be reported for investigation by writing:* ***Texas State Board of Medical Examiners*** *Attention: Investigations 1812 Centre Creek Drive, Suite 300 Austin, TX 78714-9134* *For assistance filing a complaint, call 1-800-201-9353.*

ENT CARE for kids

Disclosures

Regarding insurance contracts

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of these plans. Each one has a different stipulation regarding how often services may be rendered and more importantly, where those services may be performed. Even within the same insurance company the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We will provide that care within your insurance guidelines if you inform us EACH time of service exactly what those guidelines are. If you fail to inform us of special requirements in your contract, services such as lab work or hospitalizations may not be covered. In such instances, ENT Care for Kids and/or the selected medical/laboratory/surgical facility will BILL YOU DIRECTLY FOR THOSE CHARGES and they will be your financial responsibility.

Regarding surgical and outpatient services

An independent service or facility with no financial relationship to ENT Care for Kids may provide surgical or outpatient services for your child. We make every attempt to work with services and facilities that participate in managed care insurance programs. When "**in network**" services and facilities are not available, you may be required to pay for these expenses at "**out of network**" rates. In most instances, it is not feasible to accommodate special requests for such services. ENT Care for Kids bears no financial responsibility for its inability to arrange "in network" services for outpatient care.

Disclosure statement

If it is determined your child needs surgery, you may be referred to a surgery center the referring physician has an ownership interest in. If you object to this arrangement, you are free to request an alternate facility.

I have read and understand the policy stated above and agree to accept responsibility as described above.

_____ _____

Patient's name (please print) Date of birth

_____ _____

Signature of parent or legal guardian Date

8325 Walnut Hill Ln. #100, Dallas, TX 75231 F: 214.696.8908 T: 214.696.8900 entcareforkids.com