Weill Cornell Medicine

PATIENT FORM

Aaron Pearlman, MD

Patient's Name:				Date:
Date of Birth:	Age:	Weight:	Height:	
Reason for Visit:				
Occupation/Employer:				
Marital Status:	Name of Spouse/Significant Other:			
Children's Names & Date of Birth (if applicable):				

Please list all prior major illness/surgeries (with years):						
Operations:	1.	2.	3.			
Hospitalizations:	1.	2.	3.			
Illness/Injuries:	1.	2.	3.			
Family History (check)	❒ Heart Disease	❒ Diabetes	❒ Cancer	❒ Other:		
Which Family Member?						
Do you drink alcohol?	❒ No, Never	❒ No, but I used to	❒ Yes	How many?	Day/Week	
Do you smoke?	❒ No, Never	❒ No, I quit in	❒ Yes	Packs per day?	x	Years
Do you use illicit drugs?	❒ No, Never	❒ No, but I used to	❒ Yes	Which drug?		

Have you experienced any of the following?								
CONSTITUTIONAL			**CARDIOVASCULAR**			**GENITOURINARY**		
Weight Gain/Loss (>15 lbs)	❒ Y	❒ N	Heart Attack	❒ Y	❒ N	Frequent Urination	❒ Y	❒ N
Constant Night Sweats	❒ Y	❒ N	High Blood Pressure	❒ Y	❒ N	Prostate Problems	❒ Y	❒ N
EYES			Heart Murmur	❒ Y	❒ N	**SKIN**		
Double Vision	❒ Y	❒ N	**GASTROINTESTINAL**			Past Skin Cancer	❒ Y	❒ N
Glaucoma	❒ Y	❒ N	Chronic Diarrhea	❒ Y	❒ N	Past Radiation Therapy	❒ Y	❒ N
EAR/NOSE/THROAT			Heartburn	❒ Y	❒ N	**MUSCULOSKELETAL**	❒ Y	❒ N
Hearing Loss	❒ Y	❒ N	**ENDOCRINE**			Arthritis	❒ Y	❒ N
Ear Pain	❒ Y	❒ N	Diabetes	❒ Y	❒ N	Chronic Back Pain	❒ Y	❒ N
Ringing in Ears	❒ Y	❒ N	Thyroid Disease	❒ Y	❒ N	**RESPIRATORY**		
Balance Problems	❒ Y	❒ N	Autoimmune Disease	❒ Y	❒ N	Asthma/Emphysema	❒ Y	❒ N
Hearing Aid	❒ Y	❒ N	**NEUROLOGIC**			Chronic Cough	❒ Y	❒ N
Difficulty Breathing	❒ Y	❒ N	Headaches	❒ Y	❒ N	Tuberculosis	❒ Y	❒ N
Nosebleeds	❒ Y	❒ N	Seizures	❒ Y	❒ N	**PSYCHIATRIC**		
Nasal Drainage	❒ Y	❒ N	Stroke	❒ Y	❒ N	Anxiety	❒ Y	❒ N
Sinus Problems	❒ Y	❒ N	**HEMATOLOGY**			Depression	❒ Y	❒ N
Snoring	❒ Y	❒ N	Bruise Easily	❒ Y	❒ N	Sleep Apnea	❒ Y	❒ N
Voice Changes	❒ Y	❒ N	Anemia	❒ Y	❒ N			
If you answered YES to any of the above, please explain:								
Reviewed by: Aaron Pearlman, MD								

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

REFERRING PHYSICIAN, MEDICATION AND PHARMACY INFORMATION FORM

Patient's Name:	**Date:**
Name and Address of Internist or Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	**Fax:**

MEDICATIONS

Do you have any allergies to medications? ☐ No ☐ Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

MEDICATIONS	DOSAGE (mg, teaspoon, etc)	FREQUENCY

VACCINATION HISTORY

Date of most recent Flu Shot (ages 6 mos +)	Date of most recent Pneumonia Shot (ages 65+)

PHARMACY INFORMATION

In order to expedite prescription service, if required, we would like to have your pharmacy information on file

Pharmacy Name:	
Address	
Telephone:	**Fax:**
Patient's Signature:	

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:_____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5		☐
2. Nasal Blockage	0	1	2	3	4	5		☐
3. Sneezing	0	1	2	3	4	5		☐
4. Runny nose	0	1	2	3	4	5		☐
5. Cough	0	1	2	3	4	5		☐
6. Post-nasal discharge	0	1	2	3	4	5		☐
7. Thick nasal discharge	0	1	2	3	4	5		☐
8. Ear fullness	0	1	2	3	4	5		☐
9. Dizziness	0	1	2	3	4	5		☐
10. Ear pain	0	1	2	3	4	5		☐
11. Facial pain/pressure	0	1	2	3	4	5		☐
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		☐
13. Difficulty falling asleep	0	1	2	3	4	5		☐
14. Wake up at night	0	1	2	3	4	5		☐
15. Lack of a good night's sleep	0	1	2	3	4	5		☐
16. Wake up tired	0	1	2	3	4	5		☐
17. Fatigue	0	1	2	3	4	5		☐
18. Reduced productivity	0	1	2	3	4	5		☐
19. Reduced concentration	0	1	2	3	4	5		☐
20. Frustrated/restless/irritable	0	1	2	3	4	5		☐
21. Sad	0	1	2	3	4	5		☐
22. Embarrassed	0	1	2	3	4	5		☐

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England.

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PAYMENT POLICY FOR IN-OFFICE PROCEDURES

The following procedures are billed as a distinct procedure from the office visit. Your health plan may consider these procedures as surgical and apply the fees for these services to your plan deductible:

- **FLEXIBLE LARYNGOSCOPY:** Involves passing a fiber optic scope thorough the nasal cavity and into the throat.

- **NASAL ENDOCOPY:** A scope attached to a light source to view areas of the nasal cavities.

- **NASAL ENDOSCOPY WITH DEBRIDEMENT OR BIOPSY:** A nasal endoscopy with removal of crusting or tissue.

By signing this form you acknowledge that you are aware of this billing policy and understand that you are responsible for the payment of any portion for the fees that may be applied to your plan deductible and/or coinsurance.

Patient Name: _____

Signature: _____ **Date:** _____
(Patient or Responsible Party)

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Head and Neck Surgery

Financial Policy

Welcome to the Department of Otolaryngology-Head & Neck Surgery.
The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the physician you are seeing.

Participating Plans

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

Non-Participating Plans

In this scenario the physician you will see does not participate in you insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Medicare

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office.

Signature of Patient or Responsible Party **Date**