Weill Cornell Medicine

Babak Sadoughi, 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: Babak Sadoughi, MD								

Weill Cornell Medicine

IF THE MAIN REASON FOR YOUR VISIT IS A VOICE PROBLEM, PLEASE FILL OUT THE FOLLOWING TWO PAGES.

Patient's Name:	
Were you referred by a physician? ❒ YES ❒ NO	If yes, whom:
When did the problem start?	Did it start suddenly or gradually?
Was there an inciting incident? ❒ YES ❒ NO	If yes, please explain:
Have you this problem before? ❒ YES ❒ NO	If yes, please explain, when, how often, and if/how it resolved:
Are you a performer? ❒ YES ❒ NO	If yes: ❒ Professionally ❒ Full Time Student ❒ Part Time Student ❒ Hobby
Do you have an important voice-related event coming up? ❒ YES ❒NO	If yes, when:
Have you missed work due to your problem? ❒ Yes ❒ NO	Have you been intubated recently? ❒ YES ❒ NO
HAVE YOU SEEN ANOTHER PHYSICIAN FOR YOUR VOICE COMPLAINT? ❒ YES ❒ NO	
If YES, please fill out a separate section below for <u>each</u> physician you have seen previously.	

Type of Physician: ❒ ENT ❒ ER ❒ Primary Care ❒ Other	
Physician's Name:	Date of Visit(s) ____/_____/______; _____/______/_______
Diagnosis(es) given with dates:	
	❒ OR I don't recall
What tests were done for diagnosis? ❒ Laryngoscopy ❒ Stroboscopy ❒ EMG ❒ CT/MRI ❒ Esophagoscopy	
Other tests:	❒ OR I don't recall
What treatment were prescribed? ❒ Steroids ❒ Antibiotics ❒ Antacids ❒ Voice rest/therapy	
Other treatments:	❒ OR I don't recall
What procedures were done for treatment? ❒ Office surgery ❒ Surgery in the Operating Room	
Other procedures:	❒ OR I don't recall

Type of Physician: ❒ ENT ❒ ER ❒ Primary Care ❒ Other	
Physician's Name:	Date of Visit(s) ____/_____/______; _____/______/_______
Diagnosis(es) given with dates:	
	❒ OR I don't recall
What tests were done for diagnosis? ❒ Laryngoscopy ❒ Stroboscopy ❒ EMG ❒ CT/MRI ❒ Esophagoscopy	
Other tests:	❒ OR I don't recall
What treatment were prescribed? ❒ Steroids ❒ Antibiotics ❒ Antacids ❒ Voice rest/therapy	
Other treatments:	❒ OR I don't recall
What procedures were done for treatment? ❒ Office surgery ❒ Surgery in the Operating Room	
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What procedures were done for treatment? ❒ Office surgery ❒ Surgery in the Operating Room	
Other procedures:	❒ OR I don't recall

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS, EVEN IF YOUR ANSWER IS "NEVER" OR "NO PROBLEM"

VHI-10: These are statements that many people use to describe their voices and the effects of their voices on their lives. *(Check the response that indicates how frequently you had the same experience within the past month)*

	Never	Almost Never	Sometimes	Almost Always	Always
My voice makes it difficult for people to hear me.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
People have difficulty understanding me in a noisy room.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My voice difficulties restrict my personal and social life.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I feel left out of conversation because of my voice.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My voice problem causes me to lose income.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I feel as though I have to strain to produce voice.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
The clarity of my voice is unpredictable.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My voice problems upset me.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My voice makes me feel handicapped.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
People ask, "What's wrong with your voice?"	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
For clinician use: Total:_____/40	Severity:				

IF YOU ARE A PERFORMER, please answer each of the following questions, even if your answer is "never" or "no problem"

SVHI-10: These are statements that many people use to describe their singing and the effects of their singing on their lives. *(Check the response that indicates how frequently you had the same experience within the past month)*

	Never	Almost Never	Sometimes	Almost Always	Always
It takes a lot of effort to sing.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I am unsure of what will come out when I sing.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My voice "gives out" on me while I am singing.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My singing voice upsets me.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I have no confidence in my singing voice.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I have trouble making my voice do what I want it to do.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I have to "push it" to produce my voice when singing.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
My singing voice tires easily.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I feel something is missing in my life because of my inability to sing.	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
I am unable to use my "high voice".	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
For clinician use: Total:_____/40	Severity:				

Additional Comments:

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

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:	

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

OTOLARYNGOLOGY (ENT)

PAYMENT POLICY FOR IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

- **Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**
- **Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**
- **Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**
- **Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.**
- **Cerumen removal: Removal of wax from the ear canals.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name: _____

(Print)

Signature: _____ **Date:** _____

(Patient or Responsible Party)

Weill Cornell Medicine

Department of Otolaryngology –
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 your 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**