



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)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:	
Which Family Member?					
Do you drink alcohol?	<input type="checkbox"/> No, Never	<input type="checkbox"/> No, but I used to	<input type="checkbox"/> Yes	How many?	Day/Week
Do you smoke?	<input type="checkbox"/> No, Never	<input type="checkbox"/> No, I quit in	<input type="checkbox"/> Yes	Packs per day?	x Years
Do you use illicit drugs?	<input type="checkbox"/> No, Never	<input type="checkbox"/> No, but I used to	<input type="checkbox"/> Yes	Which drug?	

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



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+)
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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:



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? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, whom:
When did the problem start?	Did it start suddenly or gradually?
Was there an inciting incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Have you this problem before? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain, when, how often, and if/how it resolved:
Are you a performer? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes: <input type="checkbox"/> Professionally <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/> Hobby
Do you have an important voice-related event coming up? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when:
Have you missed work due to your problem? <input type="checkbox"/> Yes <input type="checkbox"/> NO	Have you been intubated recently? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU SEEN ANOTHER PHYSICIAN FOR YOUR VOICE COMPLAINT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES, please fill out a separate section below for <u>each</u> physician you have seen previously.	
Type of Physician: <input type="checkbox"/> ENT <input type="checkbox"/> ER <input type="checkbox"/> Primary Care <input type="checkbox"/> Other	
Physician's Name:	Date of Visit(s) ___/___/___; ___/___/___
Diagnosis(es) given with dates:	
<input type="checkbox"/> OR I don't recall	
What tests were done for diagnosis?	<input type="checkbox"/> Laryngoscopy <input type="checkbox"/> Stroboscopy <input type="checkbox"/> EMG <input type="checkbox"/> CT/MRI <input type="checkbox"/> Esophagoscopy
Other tests:	<input type="checkbox"/> OR I don't recall
What treatment were prescribed? <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Antacids <input type="checkbox"/> Voice rest/therapy	
Other treatments:	<input type="checkbox"/> OR I don't recall
What procedures were done for treatment? <input type="checkbox"/> Office surgery <input type="checkbox"/> Surgery in the Operating Room	
Other procedures:	<input type="checkbox"/> OR I don't recall
Type of Physician: <input type="checkbox"/> ENT <input type="checkbox"/> ER <input type="checkbox"/> Primary Care <input type="checkbox"/> Other	
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Other treatments:	<input type="checkbox"/> OR I don't recall
What procedures were done for treatment? <input type="checkbox"/> Office surgery <input type="checkbox"/> Surgery in the Operating Room	
Other procedures:	<input type="checkbox"/> 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 <u>within the past month</u>)					
	Never	Almost Never	Sometimes	Almost Always	Always
My voice makes it difficult for people to hear me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
People have difficulty understanding me in a noisy room.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My voice difficulties restrict my personal and social life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel left out of conversation because of my voice.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My voice problem causes me to lose income.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel as though I have to strain to produce voice.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
The clarity of my voice is unpredictable.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My voice problems upset me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My voice makes me feel handicapped.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
People ask, "What's wrong with your voice?"	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 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 <u>within the past month</u>)					
	Never	Almost Never	Sometimes	Almost Always	Always
It takes a lot of effort to sing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I am unsure of what will come out when I sing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My voice "gives out" on me while I am singing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My singing voice upsets me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I have no confidence in my singing voice.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I have trouble making my voice do what I want it to do.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I have to "push it" to produce my voice when singing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My singing voice tires easily.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel something is missing in my life because of my inability to sing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I am unable to use my "high voice".	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
For clinician use: Total: _____/40	Severity: _____				

Additional Comments:



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:

(Patient or Responsible Party)

Date:



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