Weill Cornell Medicine
Pediatric Otolaryngology
Head & Neck Surgery

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Under age 12

Patient's Name: Last First Middle Initial Nickname:
Date of Birth: Age:

Parent #1 Name: Parent #2 Name:

Reason for Today's Visit:

Past Medical History:

Prior Surgeries:

Hospitalizations: ❒ No ❒ Yes If Yes, list reason:

BIRTH HISTORY

Was your child born full term? ❒Yes ❒No Passed newborn hearing screen? ❒Yes ❒No

Has your child been on a ventilator? ❒Yes ❒No Medical problems at birth? ❒Yes_____ ❒No

Please check one: ❒Vaginal Delivery ❒Cesarean Section

SOCIAL HISTORY

Anyone smoke in your home? ❒Yes ❒No Is your child in a daycare or school? ❒Yes ❒No

Family Illnesses (Please list): _____

Family History of Bleeding Problems? ❒Yes ❒No If yes, please list:_____

REVIEW OF SYSTEMS

Fever	❒Yes	❒No	**Eyes:** Vision Problems	❒Yes	❒No
Issues w. weight/nutrition/feeding	❒Yes	❒No	**Cardiovascular:** Heart Problems	❒Yes	❒No
Genetic Disorder	❒Yes	❒No	**Musculoskeletal:** Developmental Abnormalities	❒Yes	❒No
Ears, Nose, and Throat:			Cough with swallowing	❒Yes	❒No
Concern w. possible hearing loss	❒Yes	❒No	Difficulty sleeping at night	❒Yes	❒No
Speech developmental issues/delay	❒Yes	❒No	Snoring (If yes, answer below)	❒Yes	❒No
Balance Disturbances	❒Yes	❒No	Loud and Obstructive	❒Yes	❒No
Nosebleeds	❒Yes	❒No	Noisy breathing/ stridor	❒Yes	❒No
Nasal Congestion/ Mouth Breathing	❒Yes	❒No	Difficulty Breathing	❒Yes	❒No
Liquids come out of nose when drinking	❒Yes	❒No	Daytime tiredness	❒Yes	❒No

In the past 6 months: Number of ear infections: _____ Tonsil infections: _____ Sinus infections: _____

In the past 12 months: Number of ear infections: _____ Tonsil infections: _____ Sinus infections: _____

Pulmonary:			**Allergy/Immunology:**		
Asthma	❒Yes	❒No	Environmental/Food Allergy	❒Yes	❒No
Cough	❒Yes	❒No	Previous Allergy Testing	❒Yes	❒No
Bronchitis/Pneumonia	❒Yes	❒No	**Gastrointestinal**		
Neurologic:			Gastroesophageal Reflux	❒Yes	❒No
Developmental Delay	❒Yes	❒No	Recurrent Spitting Up/Vomitting	❒Yes	❒No
Hypotonia	❒Yes	❒No	**Genitourinary:** Does your child bed wet	❒Yes	❒No
Hyperactivity	❒Yes	❒No	**Integumentary:** Any skin abnormalities	❒Yes	❒No
Hematology:			**Psychiatric:** Psychiatric Conditions	❒Yes	❒No
Easy Bruising	❒Yes	❒No	**Endocrine:**		
			Thyroid Abnormalities	❒Yes	❒No
Excessive Bleeding	❒Yes	❒No	Weight Issues	❒Yes	❒No

Additional Information:

The above information is accurate to the best of my knowledge

Signature of Parent or Guardian Print Name Relationship to Patient Date

FOR PHYSICIAN'S USE ONLY

I have reviewed the above information with the patient.

Physician Signature Date

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****Please be advised that office policy requires that AT LEAST ONE PARENT/LEGAL GUARDIAN is present for ALL office visits****

Patient Name: _____ Date: _____

PRIMARY CARE PHYSICIAN:	
ADDRESS:	
TELEPHONE:	FAX:
REFERRING PHYSICIAN 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:

The above information is accurate to the best of my knowledge

Signature of Patient or Guardian | Print Name | Relationship to Patient | Date

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NewYork-Presbyterian

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PEDIATRIC 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:

Cerumen removal: **Removal of wax from the ear canals**

Frenulectomy: Procedure performed to correct tongue-tie (ankyloglossia).

Nasal Endoscopy/Nasopharyngoscopy: Examination nasal cavity/sinuses and adenoids with a fiberoptic scope

Nasal endoscopy with control of epistaxis: Examination of the nasal cavity with a fiberoptic scope followed by cauterization for nosebleed.

Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.

Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.

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**