Weill Cornell Medicine

William I. Kuhel, MD

PATIENT MEDICAL QUESTIONAIRE

Name:	**Ht:**	**Wt:**	**Date:**
Occupation:			
1. Major Complaint (describe in your own words why you are coming in to the see the doctor)			
2. Referred by:			
Name and Address of your primary care physician (omit address if physician is on staff at NewYork-Presbyterian Hospital):			
3. List name and address of any physician who should receive a summary letter regarding your evaluation (use extra sheet if necessary)			
4. List all current medical conditions (diabetes, high blood pressure, heart disease, gout, tuberculosis, etc)			
5. List all surgeries and the years that they occurred:			
6. List all medications that you are taking (including eye drops, aspirin, motrin, nasal sprays, vitamins, etc.)			
7. List all drug allergies:			
Drug:	Type of reaction:		
Drug:	Type of reaction:		
Drug:	Type of reaction:		
8. Smoking History			
Do you smoke? ❒ Yes, I've smoked	Packs per day for	years	
❒ Yes, I smoke cigars or a pipe	❒ No, I never smoked		
❒ No, I quit	years ago. Prior to that I was smoking	packs per day for	years

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9. Alcohol History			
Do you drink alcoholic beverages regularly?	❒ Yes	❒ No	
If no, did you drink regularly in the past?	❒ Yes	❒ No	If Yes, year that you quit
Try to quantify exposure to alcohol:	Drinks per day for;	years; less than one alcoholic beverage per day	
But more than one per week ; Less than one alcoholic drink per week			

10. Do you have any of the following symptoms? (Please do not leave any blanks):

Constitutional		
Fevers	❒ Yes	❒ No
Chills	❒ Yes	❒ No
Sweats	❒ Yes	❒ No
Weight Loss/Gain	❒ Yes	❒ No
Gastrointestinal		
Indigestion or pain with meals	❒ Yes	❒ No
Heartburn	❒ Yes	❒ No
Skin		
History of Skin Cancer	❒ Yes	❒ No
Radiation to the head/neck region	❒ Yes	❒ No

Reviwed By: William I. Kuhel MD **Date**

Department of Otolaryngology – Head and Neck Surgery
Weill Cornell Medical College
1305 York Avenue, 5th Floor
New York, NY 10021

Telephone: 646-962-5300
Fax: 646-962-0030

CONSENT FOR RELEASE OF MEDICAL INFORMATION

NO PHYSICIAN OR INSTITUTION MAY GIVE CONFIDENTIAL INFORMTION WITHOUT THE CONSENT OF THE PATIENT. IF THE PATIENT IS A MINOR, THE CONSENT MUST BE SIGNED BY THE PARENT OR LEGAL GUARDIAN AND SHOULD BE WITNESSED

KINDLY FURNISH TO:

DR. WILLIAM I. KUHEL AT WEILL CORNELL MEDICAL COLLEGE
DEPARTMENT OF OTOLARYNGOLOGY – HEAD AND NECK SURGERY
1305 YORK AVENUE, 5TH FLOOR, NEW YORK, NY 10021

THE **FOLLOWING INFORMATION FROM MY MEDICAL RECORD:**

Patient Name: DOB:
Address:
Signature: Date:
Relationship to Patient if not Patient:
Witness:
❒ VIA FAX (number listed above)

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:	

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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**