Weill Cornell Medicine
Pediatric Otolaryngology
Head & Neck Surgery

Vikash K. Modi, MD
Alison M. Maresh, MD
Steven D. Rosenblatt, MD

Over age 12

Patient's Name:

Date of Birth: Age: Weight: Height:

Parent 1 Name: Parent 2 Name:

Reason for Today's Visit:

MEDICAL HISTORY

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 ❒ Yes Packs per day? X Years
Do you use illicit drugs? ❒ No, Never ❒No, but I used to ❒ Yes Which drug?

REVIEW OF SYSTEMS

CONSTITUTIONAL

Weight Gain/Loss (>15lbs)	❒Yes	❒No
Constant Night Sweats	❒Yes	❒No

EYES

Double Vision	❒Yes	❒No
Glaucoma	❒Yes	❒No

Ears/Nose/Throat:

Hearing Loss	❒Yes	❒No
Ear Pain	❒Yes	❒No
Ringing in Ears	❒Yes	❒No
Balance Problems	❒Yes	❒No
Hearing Aid	❒Yes	❒No
Difficulty Breathing	❒Yes	❒No
Nosebleeds	❒Yes	❒No
Nasal Drainage	❒Yes	❒No
Sinus Problems	❒Yes	❒No
Snoring	❒Yes	❒No
Voice Changes	❒Yes	❒No

CARDIOVASCULAR

Heart Attack	❒Yes	❒No
High Blood Pressure	❒Yes	❒No
Heart Murmur	❒Yes	❒No

GASTROINTESTINAL

Chronic Diarrhea	❒Yes	❒No
Heartburn	❒Yes	❒No

ENDOCRINE

Diabetes	❒Yes	❒No
Thyroid Disease	❒Yes	❒No
Autoimmune Disease	❒Yes	❒No

NEUROLOGIC

Headaches	❒Yes	❒No
Seizures	❒Yes	❒No
Stroke	❒Yes	❒No

HEMATOLOGY

Bruise Easily	❒Yes	❒No
Anemia	❒Yes	❒No

GENITOURINARY

Frequent Urination	❒Yes	❒No
Prostate Problems	❒Yes	❒No

SKIN

Past Skin Cancer	❒Yes	❒No
Past Radiation Therapy	❒Yes	❒No

MUSCULOSKELETAL

Arthritis	❒Yes	❒No
Chronic Back Pain	❒Yes	❒No

RESPIRATORY

Asthma/Emphysema	❒Yes	❒No
Chronic Cough	❒Yes	❒No
Tuberculosis	❒Yes	❒No

PSYCHIATRIC

Anxiety	❒Yes	❒No
Depression	❒Yes	❒No
Sleep Apnea	❒Yes	❒No

If you answered YES to any of the above, please explain:

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

Weill Cornell Medicine
Pediatric Otolaryngology
Head & Neck Surgery

Vikash K. Modi, MD
Alison M. Maresh, MD
Steven D. Rosenblatt, MD

****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

Weill Cornell Medicine
Pediatric Otolaryngology
Head & Neck Surgery

NewYork-Presbyterian

Vikash K. Modi, MD, FAAP
Telephone: 646-962-3017
www.weillcornell.org/vkmodi

Alison M. Maresh, MD
Telephone: 646-962-2225
www.weillcornell.org/ammaresh

Steven D. Rosenblatt, MD
Telephone: 646-962-2224
www.weillcornell.org/steven-d-rosenblatt-md

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**