Patient Name: ____________________________

Mother’s Name: ____________________________

Reason for today’s visit: ____________________________

Past Medical History: ____________________________

Prior Surgeries: ____________________________

Hospitalizations: YES NO If YES, list reason: ____________________________

Medication Allergies: YES NO If YES, list medications: ____________________________

Current Medications: ____________________________

**Birth History:**

Passed new born hearing screen? YES NO Medical Problems at birth? YES NO

Was your child born full term? YES NO Circle one: Vaginal Delivery Cesarean Section

Has your child been on a ventilator? YES NO

**Social History:**

Anyone smoke in the home? YES NO Is your child in daycare or school? YES NO

**Family Illnesses:**

**REVIEW OF SYSTEMS**

Fever YES NO Eyes: Vision problems YES NO

Issues with Weight/nutrition/feeding YES NO Cardiovascular: Heart problems YES NO

Genetic Disorder YES NO Musculoskeletal: Developmental abnormalities?

**Ear, Nose and Throat:**

Concern with possible hearing loss YES NO Difficulty sleeping at night YES NO

Speech development issues/delay YES NO Snoring (if yes, answer below) YES NO

Balance disturbance YES NO Loud and obstructive YES NO

Nosebleeds YES NO Noisy breathing/stridor YES NO

Nasal congestion/Mouth breathing YES NO Working to breathe YES NO

Liquids come out of nose when drinking YES NO Daytime tiredness YES NO

Number of ear infections _____ Tonsil infections _____ Sinus infections _____ in the past six months.

Number of ear infections _____ Tonsil infections _____ Sinus infections _____ in the past twelve months.

**Pulmonary:**

Asthma YES NO Allergy/Immunology: Environmental/Food allergy YES NO

Cough YES NO Immunologic disorder YES NO

Bronchitis/Pneumonia YES NO Previous allergy testing YES NO

**Neurologic**

Developmental delay YES NO Endocrine: Thyroid Abnormalities YES NO

Hypotonia YES NO Gastrointestinal: Gastroesophageal Reflux YES NO

Hyperactivity YES NO Recurrent spitting up/vomiting YES NO

**Hematology:**

Easy bruising/bleeding YES NO Genitourinary: Does your child bedwet? YES NO

Family history of bleeding problems YES NO Integumentary: Any skin abnormalities YES NO

Psychiatric: YES NO

The above information is accurate to the best of my knowledge.

X

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

FOR PHYSICIAN’S USE ONLY:

I have reviewed the above information with the patient.

Physician Signature Date
Referring Physician, Medication, and Pharmacy Information Form

Patient’s Name: ______________________________________ Date: __________________________

The name and address of the Primary Care Physician OR Referring Doctor:

Physician’s Name: ______________________________________
Address: ________________________________________________
______________________________________________________
Telephone: _____________________________________________
Fax: ___________________________________________________

Are there any allergies to Medications? NO Yes (please list): __________________________

Please list all current medications, including over-the-counter medications such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, etc.)

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<tr>
<th>Medication</th>
<th>Dosage (mg, teaspoons, etc)</th>
<th>Frequency</th>
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Pharmacy Information:

Pharmacy Name: ____________________________________________
Address: _________________________________________________
______________________________________________________
Telephone: _____________________________________________

*Date of most recent Flu Shot (ages 6 months +) __________ *Date of most recent Pneumonia shot (ages 65+) __________

The above information is accurate to the best of my knowledge.

X

Signature of Patient or Guardian  Print Name of Patient or Guardian  Relationship to Patient  Date
PAYMENT POLICY FOR PEDIATRIC 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 cautercization 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)