B BECKER
EAR, NOSE & THROAT CENTER

Pediatric Patient Intake Form

Patient Name: ______________________________ Date of Birth: ____________________

Social Security: ______________________________ Sex: ☐ M ☐ F

Street Address: ______________________________City: ______________State: _____ Zip: ________

Phone #s (H): ______________________________ (C): ______________________________

Family Members involved in your care. (Name & Relationship):

Name: ________________ Relationship: ______________ Name: ________________ Relationship: ______________

Person to contact in case of an emergency: ______________________________ Phone #:____________________

The following demographic questions are a requirement of the Center for Medicare and Medicaid Services Meaningful Use Program. The questions are written exactly as specified on the federal register that outlines the rules and regulations for Meaningful Use. We kindly request that you answer to the best of your ability.

What is your race?

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Hispanic
☐ Other ☐ Decline to Specify

What is your ethnic background?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

What is your preferred language?

☐ English ☐ Sign Language ☐ Spanish ☐ Other ☐ Decline to Specify

PRIMARY INSURANCE

Primary Insurance Carrier: ______________________ Address: ____

Subscribers Name: ____________________________ Relationship: ____________________ Subscriber DOB: ___________

Policy Number: ______________________________ Group Number: __________________ Subscriber SS#: ___________

SECONDARY INSURANCE

Secondary Insurance Carrier: ____________________ Address: ____

Subscribers Name: ____________________________ Relationship: ____________________ Subscriber DOB: ___________

Policy Number: ______________________________ Group Number: __________________ Subscriber SS#: ___________

OTHER MEDICAL INFORMATION

Primary Physician: _________________________________ Address/Phone Number: ______________________________

Name / Phone # of any other Dr. you see on a regular basis: ____

Pharmacy Name, Town and Phone #: ____

All lab costs are separate from our fees. We are not responsible for charges that are not covered by your insurance company. Please check which lab your insurance covers: ☐ Quest Lab Corp ☐

Referral Acknowledgement

Dear
Patient

There are many different kinds of health insurance, each of which has its own set of requirements for referrals. While we are happy to help you understand the details of your policy, it is ultimately a patient's responsibility to know whether or not they need to have a referral. If you do not have a referral for your visit, your insurance company may not pay for the services billed, and the payment will become your responsibility. Please make sure that you have a proper and up to date referral if your insurance plan requires one.

I acknowledge that I have read and understand this statement above. It is my responsibility to make sure that I have a referral for evaluation and treatment.

Patient Signature: ____ Date: ____________________

Responsible Party Signature: ____ Date: ____________________

Patient Name (Print): ____

Pediatric Health Survey Date: ____________________

Patient Name: ______________________________ Date of Birth: ____________________

Sex: M ☐ F ☐ Referring/Family Doctor: ______________________ Tel #: ____________________

Please complete this form so we can facilitate your care or provide resource information regarding available services. If you are offended by the personal nature of the question content, you do not have to answer.

CHEIF COMPLAINTS Please list all reason(s) for your child's visit: ______________________________

____

HISTORY OF PRESENT ILLNESS

How long have these problems been present and when did they start? ______________________________

Rate severity of the problem on a scale of 1 to 10: ____________

What types of activities aggravate this/these problems? ______________________________

What makes these symptoms better? ______________________________

What types of treatments/medications has your child received for this/these problems? Have they helped?

____

MEDICATIONS:

Is your child taking any medication, drugs, or pills? YES NO
If yes, please list names and dosage. Please include all prescription and NON-prescription medications (i.e. Motrin, vitamins, herbal supplements, Tylenol, etc.) ______________________________

____

EAR, NOSE, AND THROAT HISTORY

Hearing problems/ Ear Fullness / Ear Ringing	Yes ☐	No ☐
Ear infections	Yes ☐	No ☐
Speech delay	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐
Cough	Yes ☐	No ☐
Nasal blockage, congestion, or stuffiness	Yes ☐	No ☐
Postnasal drop or thick/discolored nasal drainage	Yes ☐	No ☐
Nasal bleeding	Yes ☐	No ☐
Sinus pressure, tenderness, or infections	Yes ☐	No ☐
Noisy breathing	Yes ☐	No ☐
Mouth breathing	Yes ☐	No ☐
Snoring/Sleep problems	Yes ☐	No ☐
Frequent sore throats	Yes ☐	No ☐
Number of times with strep throat this year: __________		
Swallowing problems	Yes ☐	No ☐
Hoarseness	Yes ☐	No ☐
Tongue tie	Yes ☐	No ☐
Swollen lymph nodes	Yes ☐	No ☐

Patient Name: ______________________________ Date of Birth: ______________________________

Has your child ever been diagnosed with allergic rhinitis (seasonal allergies)? YES ☐ NO ☐

a. If yes, has he/she ever had skin or blood testing before? YES ☐ NO ☐
b. Has he/she been on allergy shots before? YES ☐ NO ☐
c. What are your child's symptoms? (circle all that apply)

Runny nose Stuffy Nose Sneezing Itchy nose
Itchy throat Itchy ears Itchy/runny/watery/red eyes
Other:______________________________

d. What triggers your child's symptoms? (circle all that apply)

Pollens Grass Dust Wind
Fumes Cleaning products
Cats Smoke Perfume
Vacuuming Dogs Other animals: ________________
Mowing Exercising Temperature changes
Illness Cold weather Other:____________

Has your child ever been diagnosed with atopic dermatitis (eczema)? YES ☐ NO ☐
Has your child ever been diagnosed with chronic hives (urticaria) or angioedema? YES ☐ NO ☐
Does your child have a history of recurrent infections? (circle all that apply) YES ☐ NO ☐

Ear infections Pneumonia Sinus infections
Skin infections Bone infections Other: ______________________________

Has your child ever been treated for chronic sinus infection (antibiotics for 4-6 weeks)? YES ☐ NO ☐
Has your child ever had an adverse reaction to foods? YES ☐ NO ☐

a. Which food? ______________________________

b. What happened? ______________________________

Has your child ever had an adverse reaction to a bee, wasp, hornet, or fire ant? YES ☐ NO ☐

a. When? ______________________________

b. What happened? ______________________________

Is your child allergic to any medications? YES ☐ NO ☐

a. Medication: ______________________ Reaction: ______________________

b. Medication: ______________________ Reaction: ______________________

BIRTH HISTORY

Pregnancy complications (list any): ______________________________
Birth weight: _______ lbs. ________ oz. How many weeks gestation: ______________________
NICU stay? YES ☐ NO ☐ Newborn hearing screen results were: Pass ☐ Fail ☐ Unknown ☐

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Patient Name: ____________________

PAST MEDICAL HISTORY

Please check if your child suffers from, or has been treated for any of the following medical conditions.

Condition	YES	NO	Condition	YES	NO
Abnormal development	☐	☐	Heart disease/problems	☐	☐
Allergies	☐	☐	HIV/AIDS	☐	☐
Arthritis	☐	☐	Immune/autoimmune disorder	☐	☐
Asthma	☐	☐	Lung Disease	☐	☐
Attention deficit disorder	☐	☐	Muscle/bone disorder	☐	☐
Bleeding tendencies	☐	☐	Neurological disorder	☐	☐
Cancer	☐	☐	Seizures	☐	☐
Depression	☐	☐	Skin rash	☐	☐
Diabetes	☐	☐	Thyroid disorder	☐	☐
Down syndrome	☐	☐	Urinary/kidney disorder	☐	☐
Eye Disease	☐	☐	Migraine headaches	☐	☐
GI disorder/Reflux	☐	☐	Other:____________________		

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Please list year and reason for any past surgeries or hospitalizations your child has had: ____________________

____

____

Has your child ever been intubated? YES ☐ NO ☐

IMMUNIZATIONS

Up to date? YES ☐ NO ☐

Delayed? YES ☐ NO ☐

SOCIAL HISTORY (check all that apply)

Who has legal custody of the child? ☐ Both parents ☐ Mother ☐ Father ☐ Other: ____________________

Child Lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other family ☐ Foster family

Parents are: ☐ Married ☐ Not Married ☐ Partnered ☐ Separated ☐ Divorced

Does your child attend: ☐ Daycare ☐ Preschool ☐ Grade in school: __________

Number of siblings: __________ Pets in home? ☐ Dog ☐ Cat ☐ Other:____________________

Smokers in house, even if they do not smoke inside? YES ☐ NO ☐

Do you have the following in your home? (circle all that apply)

- Carpet in Bedroom
- Carpet in Living Area
- Drapes/Curtains
- Visible Mold/Mildew
- Window AC Unit
- Central AC/Heat
- HEPA filters

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FAMILY HISTORY

Please check if any of the following diseases run in your child's family, and indicate which relative(s)

	Father	Mother	Brother	Sister
Hypertension	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐
Stoke	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Atopic dermatitis (eczema)	☐	☐	☐	☐
Heat problem	☐	☐	☐	☐
Bleeding tendencies	☐	☐	☐	☐
Other: _____________ ___________________	☐	☐	☐	☐

PREVIOUS TESTS PERFORMED

Please indicate type of test, date, and where.

Allergy test YES ☐ NO ☐ Type, date, location: ______________________________

Sweat test YES ☐ NO ☐ Type, date, location: ______________________________

Hearing test YES ☐ NO ☐ Type, date, location: ______________________________

Genetic test YES ☐ NO ☐ Type, date, location: ______________________________

Immune test YES ☐ NO ☐ Type, date, location: ______________________________

X-ray, CT, MRI YES ☐ NO ☐ Type, date, location: ______________________________

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REVIEW OF SYSTEMS

Please CHECK if your child has had any of the following:

Constitutional
- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Fever/chills/night sweats

Eyes
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Double vision
- ☐ Corrective lenses

Ears/nose/mouth/throat
- ☐ Ear pain
- ☐ Difficulty in hearing
- ☐ Ringing in ears
- ☐ Sinus pain
- ☐ Mouth sore/ulcer
- ☐ Gum bleeding
- ☐ Pain on swallowing
- ☐ Hoarseness

Breast
- ☐ Pain
- ☐ Lump/masses
- ☐ Nipple discharge

Respiratory
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Coughing up blood

Cardiovascular
- ☐ Chest pain/tightness
- ☐ Palpitation
- ☐ Shortness of breath
- ☐ Heart attack
- ☐ Leg pain when walking
- ☐ Swelling of hands/feet/legs

Gastrointestinal
- ☐ Loss of appetite
- ☐ Constipation
- ☐ Bloating/belching
- ☐ Abdominal pain
- ☐ Nausea and vomiting
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Blood stool
- ☐ Hemorrhoids

Genitourinary
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Impotence
- ☐ Prostate problem
- ☐ Menstrual problem

Musculoskeletal
- ☐ Joint pain or swelling
- ☐ Muscle pain/bone pain

Integumentary Skin
- ☐ Skin color/texture change
- ☐ Itching
- ☐ Rashes
- ☐ Ulcers

Neurologic
- ☐ Frequent headaches
- ☐ Numbness
- ☐ Tremors
- ☐ Twitching

Psychiatric
- ☐ Anxiety
- ☐ Feeling depressed

Hematologic/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Bleeding tendencies
- ☐ Swollen lymph nodes

Endocrine
- ☐ Thyroid problems
- ☐ Frequent thirst
- ☐ Excessive sweating
- ☐ Heat/cold intolerance

I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes to health or medication.

Form completed by(print): ____

Relationship to patient: ☐ Mother ☐ Father ☐ Other: ____

Parent/Guardian Signature:____ Date:____________________

PHYSICIAN USE ONLY

I have reviewed all information in the health survey and discussed it with the patient/guardian.

Attending Physician Signature: ____ Date: ____________________

☐ Review of Systems negative except as noted above. Reviewed and discussed with patient's guarding.

Physician Initial/Date: ______________________________

☐ For Physician Examination and Endoscopy Procedures, as well as Letters to Referring Physician(s), Lab Results, Results, Radiographic Results, and other related office notes, please also see Electronic Medical Record.

Physician Initial/Date: ______________________________

Contract for Evaluation and Treatment

I understand that as part of my medical care, my Becker ENT physician may prescribe or recommend various medications. I understand that any medication may have unintended side effects, interactions, and complications, sometimes in combination with other medications. Most of these are discussed on the medication inserts. I agree to read these inserts so that I understand the risks associated with any prescribed medication. I agree to ask my Becker ENT physician at my appointment, or by phone after my appointment if I have any further questions about the prescribed or recommended medications. I agree that I will not take any medications until my questions have been answered in a manner that is satisfactory to me.

My Becker ENT physician may also prescribe for me to have further evaluation such as a blood work, cultures, CT scan, MRI, or a hearing and/or balance test. He may also recommend further evaluation by a gastroenterologist, laryngologist, neurologist, head and neck surgeon, or other medical specialist. I understand that further evaluation is often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

I understand that for any prescribed or recommended blood test, cultures, imaging test (CT, MRI), or evaluation (balance/hearing test) I should not consider this evaluation complete until I follow up with my Becker ENT physician to review the results of these test/evaluations. In the case of referral to another specialist I also understand that it is my (the patient's) responsibility to arrange and attend this appointment. If I have any difficulty doing so I will contact my Becker ENT physician and ask for assistance. Again, I understand that these evaluations and referrals are often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

Patient Signature: ______________________________ Date: ______________

Patient Name (Print): ______________________________

Physician Signature: ______________________________ Date: ______________

Physician Name (Print): ______________________________

Financial Policy

Becker Ear, Nose & Throat Center is committed to providing you with the best medical care possible. We will gladly discuss your proposed treatment with you and answer any questions.

We are happy to do our best to answer any questions regarding your health insurance coverage, but you must understand that your insurance contract is between you and your insurance company. We are not party to the contract and so we suggest that you speak to your carrier to get a clear understanding of their policies. Our relationship is with you and not with your insurance company.

If you have commercial Medical Insurance or Medicare, we will submit claims directly to the carrier. You must realize that not all services are covered by all insurance carriers. Each carrier determines what they will cover (pay for).

We participate in some insurance plans and not in others. If we are not participating providers in your medical insurance plan, then your medical insurance plan may pay some of the charges for care provided, but you are responsible for charges and fees not paid by the medical insurance company.

In most cases, your insurance company will cover the cost of a Hearing Test. An examination of 50 consecutive patients at the Becker ENT Center found that 90% (45/50) had complete coverage for their testing. If you would like to know for certain whether or not your hearing test will be covered, we encourage you to call your insurance company and inquire. If you have no coverage, your maximum out-of-pocket expense will be $90.

Have we notified you whether or not we participate in your medical insurance plan? ☐ Yes ☐ No

Payments for services, including co-payments, are due at the time care is provided. We accept cash, checks, Visa, MasterCard, and American Express. Any payment received directly by you from your insurance company for services rendered by our health care providers must be sent to our office immediately.

Returned checks may be subjected to a fee of $25.

As always, we are committed to providing you with personalized care in a comfortable setting. Please feel free to discuss our financial policy with any member of our practice.

By signing this form you are giving us authorization to submit medical claims on your behalf to your Medical Insurance Carrier or your Medicare Carrier. You are also giving us authorization to have your Medical Insurance/Medicare Carrier release information pertaining to your benefits or your benefits payable for related services to us. Also you request that payment of authorized benefits be made on your behalf to Becker Ear, Nose & Throat Center for any service furnished by said physician and/or audiologist.

Patient Signature: ______________________________ Date: ______________

Patient Name (Print): ____

Becker ENT Center Staff: ___________________________ Date: ______________