CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

Child's Name:______________________________________

Date of Birth: ___________________**Age**:____________

Pediatrician (Name and Location):____

Who referred your child to our office? :____

How can we help your child today?:____

Have they had the Flu Vaccine? Yes [ ] No [ ]

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Which local pharmacy do you use?: ____________________ **Town?**: ____________________

Is your child allergic to Latex or Rubber? Yes [ ] No [ ]

Do they have any known drug allergies? If none check here [ ]

Please list your their drug allergies along with reaction:______________________________

____

Please list ALL medications your child takes (including vitamins and OTC meds):

____

____

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Please list their past medical history: ____

____

____

Has your child had any of the following surgeries? [ ] I have never had Surgery

[ ] Ear Tubes [ ] Tonsillectomy [ ] Adenoidectomy

Please list <u>ALL</u> other surgeries:

____

____

(please turn over)

Family Medical History:

Indicate which family member beside each condition: (M) mother (F) father (C) child (B) brother(S) sister

Example: M allergies

___ Allergies ____ Bleeding Disorder ____ Migraine ____ Cancer type: ____

___ Diabetes ____ Heart Disease ____ Thyroid Disorder _______________

___ Hearing Loss ____ Stroke ____ Asthma [ ] Unknown/Adoption

Mother: [ ] Alive [ ] Deceased Cause of Death_______________

Father: [ ] Alive [ ] Deceased Cause of Death _______________

Social History:

Is your child in school? [ ] Yes [ ] No

Is your child in daycare? [ ] Yes [ ] No

Is your child meeting their developmental milestones? [ ] Yes [ ] No

If no, is it related to [ ] Speech? [ ] Hearing?

Is your child exposed to second hand smoke? [ ] Yes [ ] No

If yes [ ] at home [ ] in the car

REVIEW OF SYSTEMS: Do you have any of the following symptoms:

Constitutional:	☐fever	☐weight loss	☐fatigue	☐ daytime sleepiness
Eye:	☐vision loss	☐double vision	☐floaters	☐flashes of light
Ear, Nose, Mouth, Throat:		☐hearing loss	☐snoring	☐nasal bleeding
Cardiovascular:	☐chest pain	☐palpitations	☐passing out	☐shortness of breath
Pulmonary:	☐dry cough	☐productive cough	☐wheezing	☐coughing up blood
Gastrointestinal:	☐heartburn	☐constipation	☐diarrhea	☐trouble swallowing
Genitourinary:	☐blood in urine	☐weak urine flow	☐painful urination	
Musculoskeletal:	☐joint pain	☐joint swelling	☐muscle aches	☐swollen feet
Integumentary/skin:	☐rash	☐itchy ears	☐non-healing wound	
Neurologic:	☐dizziness	☐weakness	☐headache	☐memory loss
Psychiatric:	☐depression	☐anxiety	☐claustrophobia	☐panic attacks
Endocrine:	☐heat intolerance	☐cold intolerance	☐frequent urination	
Hematologic/lymphatic:	☐easy bruising	☐swollen glands	☐bleeding	
Allergy/immunologic:	☐spring allergies	☐fall allergies	☐summer allergies	☐winter allergies.

I certify that to the best of my knowledge, the above information is complete and accurate.

Parent or Guardian's signature: ______________________ Date: __________

Reviewing physician's signature: ______________________ Date: __________

CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

Welcome to our Office!

Please complete both sides and present a copy of your photo ID and insurance card.

Patient Information:

Last Name: ____________________ First Name: ______________ MI: __

Date of Birth: ________________ Age: ________ M/F: ________

Mailing Address: ____

City/State/Zip: ____

Phone: ________________________ Cell: ________________

Email: ________________________ Social Security #: __________

Primary Care Physician/Pediatrician: ____________________________

Employer: ____

Was your injury due to Motor Vehicle Accident? Y / N Work Related Injury? Y / N

Race: American Indian or Alaska Native ( ) White ( ) Asian ( )
Black or African American ( ) Native Hawaiian/Pacific Islander ( )
Hispanic ( ) Other ( )

Ethnicity: Hispanic or Latino ( ) Not Hispanic or Latino ( )

Insurance Information:

Primary Insurance: ______________________________________

Insured's Name: ____

Patient's Relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Holder's Birthdate: ______________ S.S. #: ______________

Secondary Insurance: ____________________________________

If patient is under 18 years of age:

Parent/Guardian Name: ____________________ S.S. #: ____________

Address: ______________________________ DOB: ____________

FINANCIAL AGREEMENT

I understand that I am financially responsible for charges for services rendered. This includes the balance after insurance has paid or denied, including deductibles, copays and co-insurance.

ASSIGNED BENEFITS

I request that payment of authorized medical benefits be made on my behalf directly to CCENT for services rendered. I authorize any holder of medical information regarding me be released to my insurance company or health plan and its agents and any information needed to determine these benefits payable for related services.

If claims are to be submitted to the insurance carrier for my visits, complete information is required along with any referrals required by my insurance carrier. If I am unable to provide this information, payment will be expected at time of visit for services rendered. An office co-pay is due the time of the visit. Any procedure performed in office may be considered by my insurance carrier as surgery and may have a separate deductible.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid and original.

I have read this information and understand it:

Name: ____ Date: __________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of the Notice of Privacy Practices of Cape cod Ear, Nose and Throat Specialists-Head & Neck Surgery, P.C. and/or the opportunity to review the Notice of Privacy Practices and retain a copy. This agreement will expire 7 years after your last office visit.

Printed Name: ______________________________________ Date: ____________________

Signature of Patient or Legal Representative: ____

Patient's Relationship to Legal Representative: ____

The Patient or the Patient's Legal Representative did not provide a written acknowledgment of receipt of the Notice of Privacy Practice's. The following explains the good faith efforts to obtain the written acknowledgment and the reasons why the acknowledgment was not obtained: __________________

____.

RELEASE OF INFORMATION

Please list all **non-medical** persons that our doctors/staff may speak to regarding you or your child's medical care (i.e. Spouse, significant other, sibling etc.):

Names: ______________________________ ___________________________________

VOICE MAIL RELEASE

I give permission to have test results or responses to my inquiries etc. be left as a voice mail on my provided phone numbers.

Signature of Patient or Parent/Guardian: ________________________ Date: _______________

Cape Cod Ear Nose and Throat Specialist does not utilize e-mail for transferring medical records.