**NORTH OKC**
**9900 Broadway Ext., Suite 200**
**Oklahoma City, OK 73114**
**Phone: 405-608-8833**
**Fax: 405-608-8818**

**NORMAN**
**2002 E. Robinson Street**
**Norman, OK 73071**
**(inside JD McCarty Center)**

Patient Name:_____ Social Security #_____

Date of Birth: _____Sex:_____ Home Phone: _____Cell:_____

Address: _____ City _____ST _____ Zip_____

County: _____ Email:_____

Race: _____ Ethnicity (circle one): Hispanic Non-Hispanic Preferred Language: _____

Primary Care Physician: _____ Phone Number:_____

Emergency Contact: _____ Phone Number: _____Relationship: _____

Emergency Contact: _____ Phone Number: _____Relationship: _____

**Parent(s) or Legal Guardian (children only)**

Parent:_____ Date of Birth:_____ Social Security Number: _____

Parent: _____ Date of Birth:_____ Social Security Number: _____

**Insurance** Company Name: _____Address:_____

Policy Number:_____ Group Number: _____ Effective Date:_____ Co-Pay: _____

Subscriber's Name:_____ Date of Birth: _____Social Security:_____

Relationship: _____ Insurance Phone _____

**Secondary Insurance** Company Name:_____Address:_____

Policy Number: _____ Group: _____ Effective Date:_____

Subscriber's Name:_____ Date of Birth: _____Social Security:_____

Relationship: _____ Insurance Phone:_____

I authorize my insurance benefits to be paid directly to Pediatric ENT of Oklahoma (if applicable). I understand that I am financially responsible for any balance. I authorize PEO or my insurance company to release any information needed to process my claims. I give permission to you and any agent of PEO to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. I am aware of this office's Notice of Privacy practices and fully understand my rights as a patient/caregiver. I am aware that PEO are independent contractors, and not participants in any form of partnership or joint venture.

Signature _____Date _____

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**AUTHORIZATION FOR TREATMENT**

I hereby authorize the physician(s) in charge of the care of the patient of Pediatric ENT of Oklahoma to administer treatment as may be deemed necessary or advisable in diagnosis and treatment of this patient.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize the physician(s) of Pediatric ENT of Oklahoma to disclose any or all information in my medical records to any person, corporation, or agency which is or may be liable for all or part of Pediatric ENT of Oklahoma charges or who may be responsible for determining the necessity, appropriateness, amount, or other manner to the physician's treatment of charge including, carriers, welfare funds, the Social security Administration or its intermediaries or carriers. I understand that my medical records may contain information that indicates that I have a communicable disease which may include but is not limited to, disease such as Hepatitis, Syphilis, Gonorrhea or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (Aids). With this knowledge, I give consent to the release of all information in my medical records, including any information concerning identity, and release Pediatric ENT of Oklahoma, it's agents and employees from liability in connection with the release of the information contained therein.

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Pediatric ENT of Oklahoma. I understand I am financially responsible for charges not covered by this assignment. You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates whom you have any balance owing for fees, items, or services.

**WAIVER OF RESPONSIBILITY OF VALUABLES**

I hereby release Pediatric ENT of Oklahoma from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

**LATE TO APPOINTMENT POLICY**

If you are a new patient, we request that you arrive 15 minutes before your appointment. If you are late by 30 minutes or more, you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience for everyone. We strive to see every patient as close to their appointment time as possible. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, and your fellow patients will thank you.

**MISSED APPOINTMENT OR "NO-SHOW" POLICY**

While we make every effort to provide a reminder email at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $50 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel less than 24 hours in advance. If this should happen more than twice, a $100 charge will be incurred for the third incident. All fees must be paid before a new appointment can be scheduled. After three missed appointments, the practice may at its discretion choose to discontinue your care.

I understand a photocopy of this document is as valid as the original.

Patient: _____ Date: _____

Or _____
(Nearest relative or responsible party)

_____ Policy holder's signature: _____
(Relationship to patient)

# FINANCIAL POLICY

***Insurance***

As a courtesy to our patients, we will gladly file the forms necessary so that you receive full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of the services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or otherwise we do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort in obtaining your efforts, we cannot force your insurance company to pay for the services we provide to you.

***Appointments/Cancelations***

We gladly reserve appointment times for you and appreciate that you have chosen Pediatric ENT of Oklahoma for your child's care. As a courtesy, we will remind you of your appointment by calling or emailing you two days prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your child's care. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $50 for regular appointments cancelled or broken without advance notice of one business day. We charge a $100 cancellation fee for cancelling surgery without providing us notice three business days prior to the appointment.

***Patient/Parent/Guardian Responsibility***

- I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.
- I acknowledge my responsibility for payment of all services provided by Pediatric ENT of Oklahoma in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
- At the initial visit, you may sign our consent for minor treatment form that allows us to render care at follow-up visits without the presence of a parent or guardian.

***Assignment and Release***

I authorize payment to be made directly to Pediatric ENT of Oklahoma by my insurance company, and I accept financial responsibility if services are not covered by my insurance. I authorize release of any medical are information requested by my insurance company. My signature below acknowledges that I have read and understand the information.

***Credit Card on File Policy***

Pediatric ENT of Oklahoma is committed to making our billing processes as simple and easy as possible. We require all initial patients provide a credit card on file with our office. We enter your card information into our credit card processor. For security reasons, only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim. Once we have filed your medical claims, you will receive an invoice notifying you of any services and charges not covered by your insurance. For your convenience, your outstanding balance will be charged to your credit card after 30 days unless we've received another form of payment from you.

Credit/Debit card number: _____ CVV: _____ Expiration: _____

Parent or Guardian's Signature: _____

I give Pediatric ENT of Oklahoma permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion. I have read a copy of Pediatric ENT of Oklahoma's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request.

Patient: _____ Date: _____

Or _____ Relationship: _____

(Nearest relative or responsible party)

# ENT CASE HISTORY

Date: _____ Patient Name: _____ Date of Birth: _____

Pediatrician/Family physician: _____

Pharmacy Name & Address: _____ Phone: _____

Have you ever seen one of our providers in the past? ◯ Yes ◯ No
Are your child's immunizations up to date? ◯ Yes ◯ No
Is the child exposed to second hand smoke? ◯ Yes ◯ No

Surgical History:

◯ Patient has had no surgeries ◯ Sinus surgery ◯ Airway surgery ◯ VP shunt
◯ Ear surgery ◯ Ear tube insertion ◯ Tonsils removed ◯ Other: _____
◯ Cleft lip/palate repair ◯ Heart surgery ◯ Adenoids removed

Allergies: ◯ No known allergies _____

Medications: ◯ No medications at this time _____

_____

**Please check any symptom below that is currently a problem for the patient:**

**General:**
- ◯ Fevers
- ◯ Chills
- ◯ Swelling
- ◯ Anorexia
- ◯ Fatigue
- ◯ Sleepiness
- ◯ Sleep problems
- ◯ Malaise
- ◯ Weight gain
- ◯ Weight loss
- ◯ Speech delay

**Eyes:**
- ◯ Eye pain
- ◯ Vision loss
- ◯ Excessive tears
- ◯ Blurring
- ◯ Diplopia
- ◯ Irritation
- ◯ Discharge
- ◯ Photophobia

**Genitourinary:**
- ◯ Urinary tract infections
- ◯ Incontinence

**Ears/Nose/Throat:**
- ◯ Ear pain/discharge
- ◯ Tinnitus
- ◯ Decreased hearing
- ◯ Nasal obstruction or discharge
- ◯ Nosebleeds
- ◯ Sore throat
- ◯ Hoarseness
- ◯ Difficulty swallowing

**Cardiovascular:**
- ◯ Chest pain
- ◯ Palpitations
- ◯ Syncope
- ◯ Dyspnea on exertion
- ◯ Orthopnea
- ◯ Peripheral edema

**Respiratory:**
- ◯ Cough
- ◯ Difficulty breathing
- ◯ Excessive sputum
- ◯ Hemoptysis
- ◯ Wheezing

**Gastrointestinal:**
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Change in bowel habits
- ◯ Abdominal pain
- ◯ Melena
- ◯ Hematochezia
- ◯ Jaundice

**Musculoskeletal:**
- ◯ Back pain
- ◯ Joint pain
- ◯ Joint swelling
- ◯ Muscle cramps
- ◯ Muscle weakness
- ◯ Stiffness

**Skin:**
- ◯ Rash
- ◯ Itching
- ◯ Ulcers/growths
- ◯ Excessive scarring
- ◯ Bleeding problems
- ◯ Dryness
- ◯ Suspicious lesions

**Neurologic:**
- ◯ Paralysis
- ◯ Weakness
- ◯ Seizures
- ◯ Syncope
- ◯ Tremors
- ◯ Vertigo

**Psychiatric:**
- ◯ Depression
- ◯ Anxiety
- ◯ Memory loss
- ◯ Mental disturbance
- ◯ Suicidal ideation
- ◯ Hallucinations
- ◯ Paranoia

**Endocrine:**
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Polydipsia
- ◯ Polyphagia
- ◯ Polyuria
- ◯ Weight changes

**Heme/lymphatic:**
- ◯ Abnormal bruising
- ◯ Bleeding
- ◯ Enlarged lymph nodes

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# ENT CASE HISTORY, CONTINUED

Date: _____ Patient Name: _____ Date of Birth: _____

**MEDICAL HISTORY: Please mark all conditions the patient or patient's family has had.**

| PATIENT | FATHER | MOTHER | SIBLING | CONDITION |
|---|---|---|---|---|
| | | | | Alcoholism |
| | | | | Allergic rhinitis |
| | | | | Allergy to penicillin |
| | | | | Anemia |
| | | | | Anxiety |
| | | | | Arthritis |
| | | | | Asthma |
| | | | | Atrial fibrillation |
| | | | | Attention deficit hyperactivity disorder |
| | | | | Auditory processing disorder |
| | | | | Autistic disorder |
| | | | | Bipolar disorder |
| | | | | Bleeding disorder |
| | | | | Cardiac arrhythmia |
| | | | | Celiac disease |
| | | | | Cerebral aneurysm |
| | | | | Cerebral palsy |
| | | | | Chest pain |
| | | | | Chromosomal abnormality |
| | | | | Chronic kidney disease |
| | | | | Circulatory system disorder |
| | | | | Congestive heart failure |
| | | | | Depression |
| | | | | Diabetes |
| | | | | Down syndrome |
| | | | | Epileptic seizures |
| | | | | Family history of deafness or hearing loss |
| | | | | Family history of sudden infant death syndrome |
| | | | | Gastroesophageal reflux disease (GERD) |
| | | | | Graves' disease |
| | | | | Headache |
| | | | | Hearing loss |
| | | | | Heart disease |
| | | | | High blood pressure |
| | | | | Hypothyroid |
| | | | | Impacted cerumen |
| | | | | Laryngitis |
| | | | | Leukemia |
| | | | | Migraine |
| | | | | Muscular dystrophy |
| | | | | Obesity |
| | | | | Obstructive sleep apnea |
| | | | | Pharyngitis |
| | | | | Sinusitis |
| | | | | Smoking |
| | | | | Stroke |
| | | | | Thyroid cancer |
| | | | | Vertigo |

**AUDIOLOGY CASE HISTORY**

Date: _____ Patient Name: _____ Date of Birth: _____

**What is your primary concern regarding your child's hearing and/or speech and language development?**

_____

_____

**HEARING HISTORY**

◯ Yes ◯ No Did your child pass his/her newborn hearing screening?

◯ Yes ◯ No Is there a family history of hearing loss in childhood or early adulthood?

If yes, please describe: _____

◯ Yes ◯ No Does your child currently use a hearing aid or cochlear implant? ◯ Right Ear ◯ Left Ear ◯ Both Ears

**PREGNANCY & BIRTH HISTORY**

Length of pregnancy: _____ weeks Baby's birthweight: _____ lbs. _____ oz.

◯ Yes ◯ No Did your child spend any time in the NICU after birth?

If yes, for how long and why? _____

Please check all of the following that occurred at the time of or immediately following birth:

◯ Breathing/respiratory difficulties ◯ Positive for CMV ◯ Yellow/Jaundice ◯ Cleft lip/Cleft palate

◯ Medications given to infant ◯ Low APGAR score ◯ Blue color ◯ Birth defect

◯ Other _____

**MEDICAL HISTORY**

◯ Yes ◯ No Does your child have a history of ear infections, ear drainage, or fluid behind the eardrum?

◯ Yes ◯ No Has your child had PE tubes?

◯ Yes ◯ No Does your child have any other diagnosis that we should know about?

If yes, please describe: _____

**DEVELOPMENT HISTORY (complete if it applies to your child)**

◯ Yes ◯ No Do you have any concerns about your child's speech and language development?

If yes, please describe: _____

◯ Yes ◯ No Is your child currently receiving speech, occupational, and/or physical therapy?

If yes, please describe: _____

◯ Yes ◯ No Does your child interact well with other children?

**Is there anything else you would like us to know about your child?** _____

_____

_____