Child's Name:_____

Date of Birth:_____**Age**:_____

Height:_____ **Weight:** _____

Pediatrician (Name and Location):_____

Who referred your child to our office?_____

How can we help your child today?_____

~~~~~~

Which local pharmacy do you use? _____**Town?**_____

Is your child allergic to Latex or Rubber? Yes [ ] No [ ]
Do they have any known drug allergies? Yes [ ] No [ ]

If yes list drug allergies along with reaction:_____

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

_____

_____

~~~~~~

Does your child have any of the following health problems?

[ ] Allergies [ ] Asthma [ ] ADD/ADHD [ ] Autism

[ ] Recurrent throat infections [ ] Recurrent ear infections

Please list other health problems: _____

_____

Has your child had any of the following surgeries? [ ] 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

Any pets in the home? [ ] Yes [ ] No If yes, please list _____

Has your child had a flu vaccine? [ ] Yes [ ] No

REVIEW OF SYSTEMS: Does your child 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 your insurance card and photo ID to reception.

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: _____

Did you make an appointment with us because of a Motor Vehicle Accident? Y / N

Or 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: _____

(please turn over)

1. **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.

2. **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 of 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 copay is due at 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.

Signature of Patient or Patient Representative:

***_____Date: _____**

If Patient Representative, please print name: _____

3. **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 Patient Representative:

***_____Date: _____**

4. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

The undersigned acknowledges receipt of the Notices of Privacy Practices of Cape Cod Ear, Nose and Throat Specialist and/or the opportunity to review the Notice of Privacy Practices and retain a copy.

Signature of Patient or Patient Representative:

***_____Date: _____**

5. **RELEASE OF INFORMATION**

Please list all non-medical persons that we may speak to regarding you or your child's medical care.

1._____

2. _____

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

_____

_____