MINOR PATIENT MEDICAL HISTORY

BROWARD ENT
CONSULTANTS, PL

5511 North University Drive, Suite 101B
Coral Springs, FL 33067

Phone 954-755-4002 | Fax 954-755-5010
www.myENTmd.com

Name: _____

DOB: _____ Height _____ Weight _____

Today's date: _____

Referring doctor: _____

Previous ENT consultations: _____

What is the main reason for today's visit?

_____

How long has this been a problem? _____ Hours __ Days ____ Weeks ___ Months ___ Years

Please list any other complaints you want to discuss today _____

_____

Who is the child's pediatrician or family doctor? _____

Has your child ever taken antibiotics, over the *counter meds or* other medications for this problem? ☐Yes ☐No

If so, please list: _____

Have X-rays, CT scans, MR1 scans or allergy tests been obtained for this problem? ☐Yes ☐No

If so, when and where were they taken? _____

Past Medical History

Was your child born full term? ☐Yes ☐No

Any problems with the child's growth and development? ☐Yes ☐No

If so, please explain: _____

Please write down any **previous surgeries** and the approximate dates

_____

_____

Does your child have any **medical problems** that require regular visits to the doctor? (Please check):

☐ADD / ADHD
☐Anemia
☐ Asthma / Reactive Airway Disease
☐ Bleeding problems/Bruising
☐ Cancer (type) _____
☐ Leukemia / Lymphoma
☐ Diabetes
☐ Ear Infections
☐ Eye Infections
☐ Gastrointestinal Problems
☐ Heart Murmur
☐ Liver / Kidney Disease
☐ Migraine Headache
☐ Muscle / Bone Problems
☐ Reflux / Heartburn
☐ Sinus Problems
☐ Skin Disease / Rash
☐ Thyroid Gland Problem

Other: _____

List all medications, including aspirin, other the counter medicines and vitamins, your child takes regularly:

_____

_____

List ALL medications or substances your child is allergic to: _____

_____

Family history - Please list any blood relatives that have or have had any of the following:

☐ Hearing loss How related_____
☐ Heart trouble How related_____
☐ Bleeding / Clotting problems How related_____
☐ Cancer How related_____
☐ Asthma / Allergies How related_____
☐ Sleep apnea / uses CPAP How related_____

Social History

Who lives at home with the patient? _____

Does anyone at home smoke? ☐ Yes ☐ No Are there pets in the home? ☐ Yes ☐ No Is the child in school or day care? ☐ Yes ☐No

Review of Systems - Please circle any problems the child is currently having.

BODY(GENERAL):
☐ Fatigue
☐ Fevers
☐ Weight loss
☐ Weight gain

HEAD
☐ Headache
☐ Facial Pain
☐ Flat Spot
☐Pain

EYES
☐ Mattering
☐ Redness
☐ Dark Circles

EARS
☐ Drainage
☐ Decreased Hearing
☐ Fluid
☐ Recurrent Infection
☐ Pain
☐ Speech Delay
☐ Imbalance / Not Walking
☐ Dizziness

NOSE
☐ Drainage
☐ Stuffiness
☐ Changes in sense of smell
☐ Nasal polyps
☐ Foreign Object
☐ Bleeding
☐ Frequent Colds

ALLERGIES
☐ Sneezing
☐ Pets in Home
☐ Food
☐ Spring
☐ Summer
☐ Fall
☐ Winter

THROAT
☐ Drainage
☐ Pain
☐ Tonsillitis
☐ Bad Breath
☐ Snoring
☐ Large Tonsils
☐ Noisy Breathing
☐ Throat Clearing
☐ Hoarseness
☐ Cough

NECK
☐ Large Glands
☐ Pain
☐ Cust / Lump
☐ Thyroid Problems

LUNGS
☐ Asthma
☐ Wheezing
☐ Bronchitis

HEART
☐ Murmur
☐ Surgery
☐ Extra Beats

STOMACH
☐ Depression
☐ Insomnia
☐ Anxiety/panic attacks
☐ Heartburn

MUSCLE / BONES
☐ Joint Pain
☐ Joint Swelling
☐ Weakness

URINARY TRACK
☐Frequency
☐Burning
☐Stones

NEUROLOGICAL
☐ Seizures
☐ Numbness
☐ Paralysis
☐ Tremor

PSYCH
☐ Attention Deficit
☐ Depression
☐ Anxiety

SKIN
☐ Eczema
☐ Itching
☐ Hives
☐ Rash
☐ Moles

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PATIENT INFORMATION

Patient name:_____
Last First Middle

SSN:_____ Date of birth:_____ Sex: ☐F ☐M

Marital status: ☐single ☐married ☐widow/er ☐divorced

Home
Address:_____
Street city state zip code

Home phone:_____ Cell phone:_____

Work phone:_____ Spouse phone: _____

Primary care physician:_____ Phone _____

Pharmacy name:_____ Phone _____

Email address_____

Insured name_____ DOB_____

Insurance name_____ PPO/HMO

Insurance id #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. Madasu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature_____ Date_____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights, to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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CANCELLATION POLICY/NO SHOW POLICY/SAME DAY CANCELLATION

Cancellation/ No Show Policy for Dr.Madasu Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.
Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee. This will not be covered by your insurance company.

If you have a Monday morning appointment, we must hear back from you to confirm this appointment by Friday afternoon, otherwise your appointment will be cancelled.

I hereby understand that Dr. Madasu, Broward ENT consultations, will contact me the day before my appointment and if they do not receive a confirmation back the appointment will be cancelled.

Scheduled Appointments
We understand that delays can happen however we must try to keep the other patients and doctors on time.
If you arrive 15 minutes past your scheduled appointment time, we will have to reschedule the appointment.

Account balances
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patient/Guardian Signature: _____

Date: _____

Patient Account #: _____
(Office Use Only)

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AUTHORIZATION TO RELEASE INFORMATION

I HEARBY GIVE MY PERMISSION TO **BROWARD ENT CONSULTANTS** TO RELEASE A COPY OF MY MEDICAL RECORDS (ANY DIAGNOSTIC TESTING / ALLERGY TESTING / PHYSICIAN'S NOTES / VISIT NOTES / OP REPORTS OR OTHER LISTED BELOW)
OTHER _____ DATE_____

PATIENTS SIGNATURE _____ DATE _____

ADDRESS: 5511 N UNIVERSITY DR. SUITE 1018 CORAL SPRINGS FL, 33067
PHONE NUMBER: 954-755 4002 FAX NUMBER: 954-755-5020

I HEARBY RELEASE THE FACITILY FROM ANY LIABILITY WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED

PAITENT'S NAME PRINTED_____DATE _____

PATIENT'S NAME SIGNED _____ DATE _____

THE INDIVDIUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUALS NFORMATION OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITIES TO RECEIVE A COPY OF THISS AUTHORIZATION FORM UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHOR IZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PROVIDING ORGANIZATION IN WRITING, BUT IF I DO, IT WON'T HAVE ANY AFFECT ON ANY ACTIONS THEY TOOK BEFORE THEY RECEIVED THE REVOCATION

I HEARBY AUTHORIZE THE RELEASE OF MY RECORDS AND AUTHORIZATION TO DISCLOSE INFORMATION TO THE FOLLOWING

NAME_____ SIGNATURE _____

CONTACT_____ RELATIONSHIP _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY

PATIENTS NAME_____DATE OF BIRTH _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY _____

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
*YOU MAY NOT USE THIS FORM TO RELEASE INFORMATION FOR TREATMENT OR PAYMENT EXCEPT WHEN THE INFORMATION TO BE RELEASED IS PSYCHOTHERAPY NOTES OR CERTAIN RESEARCH INFORMATION