

CHILD

rev 04/20/16

PATIENT INFORMATION – PLEASE PRINT

PATIENT

Last Name First Name Middle Initial (_____) Nickname

Sex: Male Female
Phone Number (Circle One) Date of Birth Social Security Number

Address City / State / Zip

PARENTS:

If address information is the same, please write same.

FATHER

MOTHER

_____ Name	_____ Name
_____ Social Security Number Date of Birth	_____ Social Security Number Date of Birth
_____ Address	_____ Address
_____ City / State / Zip	_____ City / State / Zip
_____ Home Phone Cell Phone	_____ Home Phone Cell Phone
_____ E-Mail	_____ E-Mail

EMPLOYER

EMPLOYER

_____ Name	_____ Name
_____ Work Phone	_____ Work Phone

INSURANCE:

_____ Primary Insurance Company	_____ Secondary Insurance Company
_____ Policy Holder's Name	_____ Policy Holder's Name

OTHER:

Has any other member of your family been seen in our office? Yes / No

If so, please list them: _____

Our office is not a third party to any court decree in a divorce matter. The parent that brought the child in for the initial visit will be billed for any balance after insurance.

PRESENT ALL INSURANCE CARDS TO RECEPTIONIST TO COPY FOR OUR RECORDS

Patient's Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ /ft _____ /inches Weight _____

Current Problem _____

Number of occurrences of this problem within the past 12 months _____

Has the child had any x-rays, CT's, MRI's, ultrasounds, sleep study or other tests recently? Yes No

If so, when and where _____

Referring Doctor (if referred): _____
(Name) (Town) (Phone)

Primary Care Doctor: _____
(Name) (Town) (Phone)

How did you hear about our practice? Physician Family/Friend Internet Other _____

When was the last time you had your hearing tested? _____

CURRENT MEDICATIONS

(Prescription, Over the Counter, Supplements – Vitamins & Herbs, Birth Control, Aspirin)

_____	_____	_____	_____
<i>(medication)</i>	<i>(strength & frequency)</i>	<i>(medication)</i>	<i>(strength & frequency)</i>
_____	_____	_____	_____
<i>(medication)</i>	<i>(strength & frequency)</i>	<i>(medication)</i>	<i>(strength & frequency)</i>
_____	_____	_____	_____
<i>(medication)</i>	<i>(strength & frequency)</i>	<i>(medication)</i>	<i>(strength & frequency)</i>
_____	_____	_____	_____
<i>(medication)</i>	<i>(strength & frequency)</i>	<i>(medication)</i>	<i>(strength & frequency)</i>
_____	_____	_____	_____
<i>(medication)</i>	<i>(strength & frequency)</i>	<i>(medication)</i>	<i>(strength & frequency)</i>

Preferred Pharmacy: _____
(name) (location) (phone)

PAST SURGERIES

ALLERGIES: Yes No
(Include allergies to medications and the adverse reactions)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SMOKING STATUS

Never Smoked Former Smoker Occasional Smoker Daily Smoker

THE GOVERNMENT IS REQUESTING THE FOLLOWING INFORMATION: (You may mark "Decline")

RACE
 Caucasian Black Hispanic Asian Native American Other Decline

ETHNICITY
 Latino/Hispanic Other _____ Decline

FOX VALLEY EAR, NOSE AND THROAT ASSOCIATES, S.C.

Authorization for Payment & Insurance Information, Consent for Release & Use of Confidential Information, and Receipt of (or opportunity to review) Notice of Privacy Practices

Authorization for Payment & Insurance Information:

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. If Fox Valley Ear, Nose and Throat Associates, S.C. is not a participating provider for my plan, I will pay in full at the time of service. It is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

1. I will provide Fox Valley ENT with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.
2. I will pay for all applicable co-pays and outstanding patient balances as they become due. I understand that Fox Valley ENT is not a representative of my insurance company, and therefore, cannot guarantee benefits quoted or paid. If I have questions about my benefits I will contact my insurance company directly.
3. For a work-related injury Fox Valley ENT will bill my worker's compensation carrier only if written approval is received from my employer. However, I understand that I must also give my medical insurance card in case of the claim being denied.

I understand that any patient balances not paid after 90 days will be assessed with a \$10 finance charge each month the balance remains unpaid. I will be responsible for all costs of collecting monies owed, including interest, court costs, and collection agency and attorney fees. I will also be responsible for bank fees from returned checks.

NO SHOW POLICY: I understand a \$40 fee will be charged for a missed appointment which was not cancelled prior to my scheduled appointment time. My insurance will NOT cover this charge.

Consent for Release & Use of Confidential Information:

I hereby authorize Fox Valley Ear, Nose and Throat Associates to release all information necessary to secure payment for all services performed by David S. Hemmer, M.D. & Glen K. Lochmueller, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original.

Notice of Privacy Practice:

I have been given the opportunity to review the Notice of Privacy Practices, and a copy has been made available to me.

Patient Name (Print)

Patient Date of Birth

Signature (Patient or Guardian)

Relationship to Patient (if other than self)

Date: _____

FOX VALLEY EAR, NOSE & THROAT ASSOC., S.C.

David S. Hemmer, M.D., F.A.C.S.
Glen K. Lochmueller, M.D., F.A.C.S.

Patient Notification for Insurance Payment Policies for Certain In-Office Procedures and Tests

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as “Surgery” and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures and tests include, but not limited to:

Flexible laryngoscopy: This procedure involves passing a thin flexible fiberoptic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Nasal endoscopy: This procedure uses the flexible fiberoptic scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Cerumen (ear wax) removal: When cerumen is impacted and requires the use of instruments and the microscope to remove, it is considered a separate procedure.

Microscope: The doctor sometimes needs to use the microscope to examine an area closely (for example the ears) in order to make a diagnosis. The use of the microscope is included in some procedures, but when it is used as part of the exam, it is sometimes a separate charge.

Audiometric testing: Hearing tests are necessary to diagnose types of hearing loss, dizziness, tinnitus and other ear disorders. Coverage for hearing tests depend on your individual insurance policy.

If you have any questions, please do not hesitate to ask.

Signature (Parent or Guardian)

Relationship to Patient

Date: _____

Fox Valley Ear, Nose & Throat Associates, S.C.

Patient Reminder Form

Patient Name: _____

Date: _____

Automatic appointment reminder preference: (Can have more than one method of reminder)

Voicemail:

Cellphone _____

Home Phone _____

Text: Cellphone _____

Email: _____

Pt initials _____