Fox Valley
Ear, Nose & Throat
Associates

Child

Patient Information - Please Print

Patient:

Last Name: ____________________ First Name: ____________________

Middle Initial: ____________________ Nickname: ____________________

Phone Number: ____________________ Sex: ☐ Male ☐ Female

Date of Birth: ____________________ Social Security Number: ____________________

Address: ____

City / State / Zip: ____

Parents:

If address information is the same, please write same.

Mother:

Name: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Address: ____________________

City / State / Zip: ____________________

Home Phone: ____________________

Cell Phone: ____________________

E-Mail: ____________________

Employer

Name: ____________________

Work Phone: ____________________

Father:

Name: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Address: ____________________

City / State / Zip: ____________________

Home Phone: ____________________

Cell Phone: ____________________

E-Mail: ____________________

Employer

Name: ____________________

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

FOX VALLEY
EAR, NOSE & THROAT
ASSOCIATES

Patient's Name: ______________________ Today's Date: ____________

Date of Birth: ____________ Age: ______ Height: _____ /ft _____/inches Weight: ____________

Current Problem: ______________________

Number of occurrences ofthis 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 & Herbals, Birth Control, Aspirin)

Medication	Strength & frequency	Medication	Strength & frequency

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 & Throat
Associates

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 al 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 currert 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 incase 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 al 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 ot 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 of 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): ____________________

Today's date: ____________________

FOX VALLEY
EAR, NOSE & THROAT
ASSOCIATES

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

Patient Name: ____

Please be aware that certain procedures and tests 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 and tests 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 aseparate 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: ____________________

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Patient Reminder Form

Patient:

Patient Name: ______________________________ Date: ______________________________

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

☐ Voicemail

  ☐ Cellphone: ______________________________

  ☐ Home Phone: ______________________________

☐ Text Cellphone: ______________________________

☐ Email: ______________________________

Patient initials: __________