Pediatric Patient History

(form must be completely filled out)

Office Use Only	Verified initials _____
	Verified date _____

PATIENT INFORMATION Home Ph _____ Cell Ph _____ Date _____

Preferred Email _____

CHILD INFORMATION (if under 18 years old)

Name _____
Last First Middle

Date of Birth _____ /_____ /_____ Sex _____

Preferred Language _____ Race _____ Ethnicity ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Declined to State

Address _____
Street City State Zip

School Name _____ School Phone _____

FATHER/GUARDIAN INFORMATION

Name _____ Relationship to Patient _____
Last First Middle

Date of Birth _____ /_____ /_____

Address if different from above _____

Employer _____ Occupation _____

Address _____ Phone _____

MOTHER/GUARDIAN INFORMATION

Name _____ Relationship to Patient _____
Last First Middle

Date of Birth _____ /_____ /_____ Age _____

Address if different from above _____

Employer _____ Occupation _____

Address _____ Phone _____

IN CASE OF AN EMERGENCY NOTIFY (NOT LIVING WITH YOU - PREFERRABLY LOCAL)

Name _____ Phone _____

Relationship to Patient _____

Referring Physician _____
(required) Last First

Personal Physician _____
Last First

Waco Ear, Nose & Throat requires payment in full of insured co-payments and any prior outstanding balances:

☐ Cash ☐ Check ☐ Money Order Credit Card: ☐ Visa ☐ Mastercard ☐ Discover

PRIMARY INSURANCE INFORMATION (please provide forms for photocopying - Primary)

Primary Insurance _____

Policy Holder _____ Relation to Patient _____

Policy Holder Birthdate _____

SECONDARY INSURANCE INFORMATION (please provide forms for photocopying - Secondary)

Secondary Insurance _____

Policy Holder _____ Relation to Patient _____

Policy Holder Birthdate _____

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me.

ASSIGNMENT OF BENEFITS

I hereby assign directly to Waco Ear, Nose & Throat all medical insurance benefits, if any, payable for services rendered. I ultimately understand I am financially responsible for all charges. I understand the details of my insurance plan, and agree to comply with them. I understand my portion of payment (including co-pays) are due on or prior to the day service is rendered. I hereby authorize the physician to release any medical or other information to my insurance carrier.

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION FROM WACO EAR, NOSE & THROAT

I hereby authorize Waco Ear, Nose & Throat to release medical information regarding my care and treatment by Waco Ear, Nose & Throat as provided in this Authorization. I understand that this Authorization applies to all record created in the course of my treatment on the date(s) listed below, including information regarding my billing records, medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status, including AIDS/HIV.

Person(s) to whom the Use and/or Disclosure May Be Made. The specific persons or class of persons to whom a use and/or disclosure of my Protected Health Information may be made are as follows:

_____

_____

In consideration of the release of information by Waco Ear, Nose & Throat in accordance with this request, I hereby release Waco Ear, Nose & Throat, its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof.

This Authorization is subject to revocation at any time in the form of written notice from me, except to the extent that Waco Ear, Nose & Throat has already taken action in reliance theron. If not previously revoked, this Authorization shall expire three hundred sixty-five (365) days from the date of my signature. A photocopy or facsimile is valid as the original. Beyond this agreement, I understand that my care and treatment has implied consent as it pertains to the continuum of that care and treatment.

I understand that Waco Ear, Nose & Throat may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility of benefits on the provision of this Authorization.

I understand that any information disclosed pursuant to this Authorization is subject to re-disclosure by the recipient and may no longer be protected by law. I understand that I must be provided with a copy of this signed Authorization.

_____ _____

Signature of Patient or Legally Authorized Representative | Date of Signature

_____ _____

Relationship to Patient | Date of Signature

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out his form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report it you wish.

Full Name _____ Appointment Date _____

Height: _____ Weight: _____

Pharmacy Preference (include location) _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

☐ No ☐ Yes If yes, please fill list below include dosages. (If you have a list we will make a copy)

Medication Name	Dosage	How often taken

Are you allergic to ANY medications? ☐ No ☐ Yes If yes, please list below.

Medication Name	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being number or put to sleep)? ☐ No ☐ Yes

Have had any ear, nose or throat surgery? ☐ No ☐ Yes (type and date)

_____

Have you had any surgeries? ☐ No ☐ Yes (type and date)

_____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ No ☐ Yes If yes, please explain.

_____

_____