Connecticut Pediatric Otolaryngology

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New Patient Information Form
(available at www.ctentkids.com)

- **Bring your child's insurance card and referral form (if required) to every visit.**
- **Co-payments must be paid in full at the time of the appointment.**
- **Please bring any important tests and x-rays as well.**

Today's Date: _____/_____/_____ Person filling out this form: _____

Patient's Name: _____
First Last Nickname

Date of birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____
Street City State Zip

Phone (circle the best number to reach you during the day):

Home: ( ) _____ Cell: ( ) _____

Work: ( ) _____ Other (specify): _____ ( ) _____

Email (we will not share your address with anyone): _____

Please check if we may contact you by email for… ☐ appointment reminders ☐ clinical follow-up

Name of your pharmacy: _____ Street & town: _____

School or **daycare**: _____ Grade: _____

Special interests, hobbies,
extracurriculuar activies: _____

Parent Information (please check): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ _____

Name: _____ Lives with patient? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Parent Information (please check): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ _____

Name: _____ Lives with patient? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Names and ages of **other children** in the family: _____

Pediatrician or Primary Care Provider: _____
Name Address Phone

Others (doctors, therapists, etc.)
involved in your child's care: _____

Who referred you to us? ☐ Primary Care Doctor ☐ Self ☐ Other _____

Medical History

Patient's Name: _____

What is the **problem** you are here for today? _____

When did this problem begin? _____

Has there been any treatment for this problem yet? _____

Medications (and doses if known) your child is taking: _____

Medication and food allergies and the reaction that occurs: _____

Overnight hospitalizations and why: _____

Prior **surgeries**: _____

Patient's **weight**: _____ lbs. (OR) _____ kg.

Are your child's **immunizations** up to date? ☐ Yes ☐ No

Has your child ever been diagnosed or treated for **problems in any of the following body systems**? Please explain.

EYES	Vision problems / Crossed eyes Treatment:
EAR, NOSE & THROAT	Frequent ear infections / Hearing loss / Ringing / Sinus Infections Mouth breathing / Snoring / Difficulty swallowing/ Frequent strep throat or tonsillitis / Voice problems, Speech problem / Language delay Treatment:
HEART	Abnormal murmurs / Heart defect Treatment:
RESPIRATORY & LUNGS	Wheezing / Asthma / Recurrent croup / Pneumonia / Excessive coughing RSV Bronchiolitis / Bronchitis Treatment:
GASTRO-INTESTINAL (GI)	Feeding difficulties, Gastroesophageal Reflux / Liver disease / Hepatitis / Colitis / Vomiting / Diarrhea / Frequent stomachaches Treatment:
ENDOCRINE	Diabetes / Thyroid / Excessive thirst or hunger / slow or excessive growth Treatment:

URINARY & KIDNEY	Urinary infections / Kidney problems / Bedwetting Treatment:
MUSCULO-SKELETAL / JOINTS & BONES	Arthritis / Fractures (including nasal fracture) / muscle weakness / Limp Treatment:
NEUROLOGICAL & BRAIN	Headaches / Migraines / Seizures/convulsions / Motor Tics / Autism / Pervasive developmental delay (PDD), Meningitis, Fainting or dizziness, Cerebral Palsy (CP), head injury or trauma, Treatment:
PSYCHOLOGICAL & BEHAVIORAL	Depression / ADD / Hyperactivity / Drug problem / Psychiatric disorder Treatment:
SKIN	Eczema / Recurrent rashes / Hives Treatment:
HEMATOLOGIC	Anemia / Bleeding tendency / Blood disorder / Lymphoma / Leukemia, Sickle Cell Disease Treatment:
ALLERGY & IMMUNOLGY	Immune deficiency / HIV / AIDS Environmental allergies: Treatment:
CONGENITAL ANOMALIES & GENETIC PROBLEMS	Syndrome / Abnormal facial development / Cleft lip or palate / Craniofacial abnormality Treatment:

Family Medical History

Has any member of the patient's extended family experienced problems with any of the following?
If so, please specify who (relation to the patient) and explain the problem:

Bleeding Problems: _____

Anesthesia Problems: _____

Ear/Nose/Throat Issues: _____

Genetic/Chromosome Issues: _____

Hearing Issues: _____

Init: ☐

Financial Agreement

It is the patient or the patient's/guardian's responsibility to pay for the services rendered. If the patient/guardian provides us with current health insurance information, we will process the claim directly with the insurance company. The patient/guardian is responsible for any co-payment, deductibles, or other amounts not payed by your insurance company. **We accept cash, personal checks, Visa and Mastercard.**

When necessary, we will do our best to work out financial arrangements satisfactory to both the patient and this medical practice. Once an arrangement is made, the patient/guarantor is expected to follow that payment plan.

Questions about your insurance coverage and benefits should be directed to the insurance company.

By signing at the bottom of this page, you authorize all payments due for medical benefits to be made directly to Connecticut Pediatric Otolaryngology, LLC (CPO).

Privacy Statement

A notice of Privacy Practices is available to all patients and is posted in the office. Our privacy policy and information management are in compliance with applicable laws, including The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing at the bottom of this page, you authorize Connecticut Pediatric Otolaryngology, LLC to release any information pertaining to the examination, treatment, history and medical expenses to my insurance carrier(s) for claim processing purposes. This release may include review, copying and/or electronic transfer of documents for consideration/payment of claims by the insurer.

Authorization for Access/Release of Information

I authorize Connecticut Pediatric Otolaryngology, LLC and released entities to obtain information from those that have been directly involved in my child's care as it pertains to his/her continued care at Connecticut Pediatric Otolaryngology, LLC.

INFORMATION TO BE RELEASED OBTAINED (VERBAL OR WRITTEN FORM) AS FOLLOWS:
Dates of service: ☐ all available medical records OR ☐ (specify dates):
Purpose of disclosure: ☐ coordination of medical care ☐ OR (specify):

- I understand that this authorization will expire one year after I have signed the form or other time frame as specified: _____
- I understand that I may revoke this authorization at any time by notifying a request in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
- I understand that I am not required to sign this form in order to receive treatment or payment for my care.
- I understand that there may be a fee for a copy of my medical record.

I hereby certify that I have read the financial agreement, privacy statement and authorization for access/release of information. I agree to accept full financial responsibility for payment of the charges incurred by the named patient, including costs of collection and a reasonable attorney's fee incurred in the collection of any amounts not paid, as requited. I also agree to the specifications of the privacy release and authorization for information release.

Signature of parent/legal guardian/authorized person: _____ Date: _____

Name of insured: _____ Relationship to patient: _____

Insurance Information

- **Bring your child's insurance card and referral form (if required) to every visit.**
- **Co-payments must be paid in full at the time of the appointment.**
- **You do not need to fill out this page if you have the child's insurance card (we can just copy the card)**

Primary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim: _____
Street City State Zip Code

Policy Holder's Name: _____ SS#: _____

Date of Birth: _____/_____/_____ Relationship to Child: _____

Employer Name: _____

Secondary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim: _____
Street City State Zip Code

Policy Holder's Name: _____ SS#: _____

Date of Birth: _____/_____/_____ Relationship to Child: _____

Employer Name: _____