PEDIATRIC MEDICAL HISTORY

Date_______________

(Confidential)

Name ____ Age _________ SS#_________________________

Last First Middle

Chief Complaint ____

(What is the main problem that brings you here?)

Current
Medications____

____

Drug Allergies ____

Has your child taken any Aspirin, Ibuprofen in the last two weeks? **Y** **N**

If so, when? _________________________ Do they bleed or bruise easily? __________________________

Referring Doctor______________________

Phone (_______) ___________________________

Address ________________________________

Pediatrician ___________________________

Phone (_______) ___________________________

Address ________________________________

REVIEW OF SYSTEMS

(Please check all that apply)

GENERAL
____ Birth Defects
Describe_____________________________
____ Weight Loss
____ Fever or Chills
____ Bad Reaction to Anesthesia
Self____________ Family ______________
Describe ______________________________
____ Easy Bleeding or Bruising
Self____________ Family ______________
Describe ______________________________
____ Recent Trauma or Injury
Describe ______________________________

HEAD, EYE, EAR, NOSE AND THROAT
____ Headache
____ Yellow or Green Nasal Drainage
____ Clear Nasal Drainage
____ Cough
____ Bad Breath
____ Personality Changes (Irritable, Lack of Energy etc.)
____ Hearing Loss
____ Delayed Speech Development
____ Ear Drainage
____ Ear Pain
____ Double Vision/Lazy Eye
____ Dizziness
____ Nasal Obstruction
____ Snoring
____ Stops Breathing at Night
____ Noisy Breathing
____ Hay Fever
____ Hoarseness
____ Thyroid Problems
____ Other __________________________

CHEST
____ Asthma
____ Shortness of Breath
____ Lung Disease
____ Cystic Fibrosis
____ Other __________________________

CARDIOVASCULAR
____ Heart Disease (Congenital)
____ High Blood Pressure
____ Heart Murmur
____ Other __________________________

GASTROINTESTINAL
____ Difficulty Swallowing
____ Nausea or Vomiting
____ Stomach Pain
____ Ulcers
____ Liver Disease
____ Reflux
____ Hernia
____ Other ____________________

GENITOURINARY
____ Painful Urination
____ Blood in Urine
____ Other _________________________

NEROLOGIC
____ Seizures
____ Weakness
____ Daytime Sleepiness

PSYCHOLOGICAL
____ Depressed
____ Hyperactive
____ Attention Deficit Disorder

PAST HISTORY

Please list all surgical procedure; particularly sinus, ear, tonsil and/or adenoid surgeries:

Surgical Procedures ___________________________________ Date ________________ Dr. ______________

___________________________________ Date ________________ Dr. ______________

___________________________________ Date ________________ Dr. ______________

Medical Illness ___________________________________ Date ________________ Dr. ______________

___________________________________ Date ________________ Dr. ______________

___________________________________ Date ________________ Dr. ______________

Hospitalizations ___________________________________ Date ________________ Dr. ______________

___________________________________ Date ________________ Dr. ______________

BIRTH HISTORY

Birth Weight: ________ Pounds _______ Ounces Was this child born early? Y N

Did this child pass His/Her Newborn Hearing Screen? Y N

WERE THERE ANY PROBLEMS:

Immediately after birth? Y N If Yes, Please Describe____

In the first six months after birth? Y N If Yes, Please Describe_______________________________________

During Pregnancy? Y N If Yes, Please Describe ____

FAMILY HISTORY

Mother is ____ Alive ____ Deceased Father is ____ Alive ____ Deceased

Medical Problems _________________________ Medical Problems _________________________

Does anyone in the family have Cystic Fibrosis, Sickle Cell Anemia, or Deafness? Y N

Blood Relatives' Medical Problems ____

SOCIAL HISTORY

Is your child currently in Day Care? Y N Does anyone in the family smoke? Y N

Is your child around Cigarette Smoke? Y N If yes, How Frequently? ____________ How Much? ___________

Does your child have difficulty sleeping? Never Often Sometimes Getting to Sleep Staying Asleep

Does your child have behavioral problems? Y N If Yes, Please Describe __________________________________

GEORGIA NASAL AND SINUS INSTITUTE, P.C.

Patient Information

Date______________________________ Allergies _______________________________ Male ______ Female ______

FULL LEGAL NAME ____ SS#__________________________________

Address ____

Street City State Zip

Date of Birth ______--______--__________ Home Phone (______) ________________ Student FT ____ PT ____

Employer ______________________________ Work Phone (_____) _________________ Employed FT ____ PT ____

Marital Status S M D W Cell Phone (_____) _________________

Name of Spouse _____________________________________ Work/Cell Phone (______) ________________________

Emergency Contact _________________________ Phone(_____) ______________ Relationship _________________

Pharmacy that you use regularly: Name_________________________________ Phone (______) _________________

Responsible Party (Please complete if different from above or if the patient is a minor)

Name ___________________________ SS#_________________________ Date of Birth _____--______--_________

Address ____

Street City State Zip

Phone ___________________________________ Relationship to Patient _______________________________________

Insurance Information

Primary Insurance

____________________________________ ID# ____________________________ Group# _______________________

Insured __________________________ Date of Birth_ ____--________--______ SS#___________________________

Relationship to Patient______________________________ Employer ____

Secondary Insurance

____________________________________ ID# ____________________________ Group# _______________________

Insured __________________________ Date of Birth_ ____--________--______ SS#___________________________

Relationship to Patient______________________________ Employer ____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or to facilitate treatment.

Signature____ Date ______________________________________

I assign all medical and/or surgical benefits, to which I am entitled, to Georgia Nasal and Sinus Institute. This assignment will remain in effect until revoked in writing by myself or an authorized person. A photocopy of this authorization will be considered as effective and valid as the original.

Signature____ Date ______________________________________

I understand that if I or an authorized person does not cancel a scheduled appointment within 24 hours prior to that appointment, or present documentation of an emergency situation in a timely manner, I will be charged with a negligent cancellation fee.

Signature____ Date ______________________________________

GEORGIA
NASAL & SINUS
INSTITUTE

FINANCIAL AGREEMENT

I hereby agree to pay for all office visits at the time service is rendered, unless I make arrangements in advance. I understand payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that having insurance does not relieve me of the responsibility to pay.

DATE________________SIGNATURE_______________________________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize GEORGIA NASAL & SINUS INSTITUTE, to furnish my insurance company(s), hospital, referring physicians and attorneys all information with regard to my medical care.

DATE________________SIGNATURE_______________________________________

AUTHORIZATION FOR MEDICARE /MEDICAID BENEFITS *(if applicable)*

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents, any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown.

In Medicare/Medicaid assigned cases the physician agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge. I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon charge determination of the Medicare/Medicaid carrier.

DATE________________SIGNATURE_______________________________________

TRICARE *(if applicable)*

I request the payment of authorizes benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CHAMPUS and it's agents any information needed to determine these benefits or the benefits payable for related services.

DATE________________SIGNATURE_______________________________________

4750 WATERS AVENUE, SUITE 112 SAVANNAH, GA 31404 * PHONE 912-355-1070* FAX 912-355-9773

GEORGIA
NASAL & SINUS
INSTITUTE

INSURANCE VERIFICATION FORM

Please Read and Answer All Questions

As the patient, it is your responsibility to provide our office with your insurance information to prevent you from incurring unnecessary medical expenses. In most cases, failure to follow procedure on your insurance plan and use of non-preferred facilities and doctors will reduce your benefits significantly. **Your signature below indicates that you have verified your insurance benefits by calling the customer service number on your insurance card, and have answered ALL questions below.** Failure to obtain this information before appointment time will cause delays as you will be required to verify benefits in the office before you will be seen by the doctor.

PATIENT NAME__________________________**INSURANCE COMPANY**______________________

ID #________________________________ **GROUP/POLICY#**______________________________

1. Is Dr. Kuhn/Dr. Melroy a preferred provider for your insurance company? ( ) yes ( ) no
   If no, do you have out of network benefits? ( ) yes ( ) no
   Deductible amount: _______________ Co-Insurance amount _________________.

2. Dr. Kuhn/Dr. Melroy are specialists. Does your insurance company require a ***referral number*** from your primary care physician (PCP) to be seen by a specialist? If so, please provide your referral number _____________________, and name of referring physician ____________________________.

3. It is very common for Dr. Kuhn and Dr. Melroy to order CT Scans for our Nasal/Sinus patients, even though you may have recently had a CT Scan. Does your insurance company require ***precertification***, or approval in advance, for a CT Scan of the Sinus/ Nasal Endoscopy/ Debridement? ( ) yes ( ) no

4. Do you have a yearly deductible to pay? ( ) yes ( ) no. If yes, amount of deductible $_____________.

5. Do you have a co-pay for office an visit? ( ) yes ( ) no If yes, amount of co-pay per office visit? $____

6. Does your insurance have a preferred laboratory for testing in the Savannah area? ( ) yes ( ) no
   Please circle name of laboratory **Memorial Medical Center** **Candler** **Other**___________

7. Does your insurance have a preferred center for radiology in the Savannah area? ( ) yes ( ) no
   Please circle name of Radiology Center. **Memorial Medical Center** **Southcoast**

8. Does your insurance policy have a preferred hospital in the Savannah area? ( ) yes ( ) no
   Please circle the name of preferred hospital. **Memorial Medical Center** **Candler/St. Joseph**

I have been informed of my insurance plan's coverage and procedures, and will be responsible for all non-covered and denied charges in addition to my deductible, coinsurance, and or copayment amounts at time of visit.

______________________________ ________________________
Signature of Patient or Guarantor **Date**