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 <u>all</u> surgical procedures; 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

During pregnancy or immediately after birth? Y N If Yes, Please Describe_____

In the first six months of life? 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 _____

Any history of allergy testing? Y N by Dr._____ Allergic to _____

Any history of allergy shots? Y N What school does the child attend? _____

GEORGIA NASAL AND SINUS INSTITUTE, P.C.

Patient Information

Date_____ Social Sec. Number _____-_____-_____ Male _____ Female _____

FULL LEGAL NAME_____

Ethnicity (Circle one): White/Caucasian, Black/African American, Asian, Hispanic, Other _____

Address _____

Street City State Zip

E-mail _____

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 (_____) _____

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*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 _____

Primary Insurance

_____ ID# _____ Group# _____

Insured _____ Date of Birth_ ____--_____--_____ SS#_____

Relationship to Patient_____ Employer _____

Secondary Insurance (if applicable)

_____ 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 _____

PRACTICE DIRECTIVE ON DISCLOSURE OF PROTECTED HEALTH INFORMATION

Frequently it becomes necessary for our Practice to contact you about information concerning your health. This includes appointment reminders, test results, prescription changes, etc. On occasion we may attempt to contact you by telephone and if we do not reach you directly but rather are connected to an answering machine or voice mail, we are required to inquire whether you authorize us to leave messages concerning information about your health. It is out practice to leave our telephone number and request that you return our call. Please advise us as to your preference.

_____ The physician(s), staff and employees of Georgia Nasal and Sinus Institute, PC, are hereby authorized to leave messages containing health information about me on my answering machine and/or voice mail should they not be able to speak with me directly.

_____ The physician(s), staff and employees of Georgia Nasal and Sinus Institute, PC, may only leave a message for me to return their call.

Further, it may on occasion be necessary to disclose your protected health information to a member of your family, other relative(s), or close friend(s). Example — When others pick up prescriptions or test results on your behalf; or when they provide care for you.

If there are individuals whom you wish to authorize to receive health information about you, please list their names and relationships below:

I hereby consent to the disclosure of protected health information about me to:

Name	**Relationship**

I understand that this list is not exhaustive, and that considering the circumstances disclosure of my protected health information may be made to other family members, relatives, and/or friends not specifically listed here.

_____ _____

Patient 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_____

MEDICARE /MEDICAID BENEFIT AUTHORIZATION *(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 its 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 BENEFIT AUTHORIZATION *(if applicable)*

I request the payment of authorized 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 its agents any information needed to determine these benefits or the benefits payable for related services.

DATE_____SIGNATURE_____

GEORGIA
NASAL & SINUS
INSTITUTE

Frederick A. Kuhn, M.D., FACS
Director

Christopher T. Melroy, M.D.

Financial Policy

November 1, 2009

We are dedicated to providing the highest quality of care and service possible. Please understand that our financial policies are an important part of your care and treatment. To deliver the best possible care at the lowest cost, we find it necessary to implement the following policies. If you have any questions, please discuss them with our staff.

Payment is due at the time service is rendered. For your convenience we accept cash, check, money order, Visa, Master Card, and FSA cards.

No patient will be seen who has an outstanding balance for which payment arrangements have not been made and kept current.

Please understand that your insurance is a contract between you and your insurance carrier and that you are ultimately responsible for your bill. We will help you receive your maximum allowable benefits and will file claims for services rendered. Please be aware that few insurance carriers cover all healthcare costs. Some pay fixed allowances for each visit/procedure, while others pay a percentage only of the costs.

All co-pays, cost shares or deductibles are due at the time of service. **The entire balance on your account is your responsibility whether your insurance pays or not.**

As a courtesy, we allow 30 days for insurance payments to be processed and received. **If your insurance carrier fails to pay its portion of your charges within 30 days or if there is a remaining balance after the insurance payment then that amount becomes your responsibility.**

If you have insurance coverage from more than one carrier, we will file a claim with the primary insurance after services are rendered. **You are responsible for any portion of the fees not paid by your primary carrier.** As a courtesy, we will submit a claim on your behalf to your secondary carrier.

All checks returned for insufficient funds will be subject to a $35 fee. Returned checks outstanding for more than 30 days and account balances older than 60 days may be subject to an additional collection fee of 5% per month. Returned checks may, in some cases, be referred to the District Attorney for collection.

If your account is turned over to our collection agency, a charge of 35% of the outstanding balance will be assessed to your account to cover the cost of collection fees.

We reserve the right to charge you for excessive appointment cancellations and "no show" appointments.

We know you have a choice among healthcare providers and appreciate the opportunity to serve you.

I have read and understand the financial policy of the Georgia Nasal and Sinus Institute, PC and agree to be bound by its terms and conditions.

_____ _____

Patient or Responsible Party Signature Date

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**

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