PATIENT REGISTRATION

ROCKY MOUNTAIN PEDIATRIC ENT ASSOCIATES

Date: _____

Health ONE Clinic Services

Patient First Name: _____ Last Name: _____Nickname: _____

Primary Residence:
Address: _____City_____State:_____

Zip: _____ Preferred contact number for primary caregiver: _____

Male ◉ Female ○ Birthdate_____ Age_____ SSN_____

Race_____ Ethnicity _____ Preferred Language _____

****Female Caregiver/Guardian:** **Relationship to child if not biological mother:** _____
Name (First, Last)_____Birthdate_____
Address_____
City, State, Zip_____SS#_____
Preferred contact number:_____ Alternate contact number:_____

Email:_____ Occupation: _____

****Male Caregiver/Guardian:** **Relationship to child if not biological father:** _____
Name (First, Last)_____Birthdate_____
Address_____
City, State, Zip_____SS#_____
Preferred contact number:_____ Alternate contact number:_____
Email_____ Occupation:_____

Emergency Contact: Name:_____ Phone:_____

Pharmacy: Name: _____ Phone: _____

**************************Referring/Primary Care Physician Information:*************************

Physician - Name: _____ Name of Practice_____
Phone #_____ **Fax Number:** _____
Address_____

How did you hear about our practice? Primary Care Physician ☐ Website ☐ Friend ☐ Advertisement ☐
Dex/Yellow Pages ☐ Other:_____ _____

Group Health Insurance Information

Primary Insurance Name: _____ Customer Services Phone#._____
Policy Holder Name: _____ SSN: _____ DOB: _____
Group/Policy #: _____ ID Number: _____

Secondary Insurance Name: _____ Customer Service Phone #_____
Policy Holder Name: _____ SSN: _____ DOB: _____
Group/Policy #: _____ ID Number: _____

Rocky Mountain Pediatric ENT Associates

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner or Audiologist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Parent/Guardian **Date**

_____

Relationship to Patient

Date_____

Patient Name_____ **Nickname**_____

DOB_____ **Age**_____

Who sent you to see us?_____

Why are you being seen today?_____

_____

Past Medical History: Has your child had any of the following health problems? Please check all that apply.

- ☐ Heart disease
- ☐ Heart murmur
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Pulmonary hypertension
- ☐ Chronic lung disease
- ☐ Bronchopulmonary dysplasia
- ☐ Cystic fibrosis
- ☐ Chronic bronchitis
- ☐ Need for supplemental oxygen?
- ☐ Pneumonia
- ☐ Difficulty swallowing
- ☐ Aspiration
- ☐ Stroke
- ☐ Seizures
- ☐ Head injury
- ☐ Cerebral Palsy
- ☐ Migraines
- ☐ Meningitis
- ☐ Cancer
- ☐ Eczema
- ☐ Diabetes
- ☐ Anemia
- ☐ Jaundice
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ Hemophilia
- ☐ Von Willebrand's
- ☐ GERD
- ☐ Chronic diarrhea
- ☐ Intestinal difficulties
- ☐ Ulcers
- ☐ Kidney infections
- ☐ Thyroid problems
- ☐ Sinus disease
- ☐ Septal deviation
- ☐ Nasal polyps
- ☐ Hearing loss
- ☐ Cholesteatoma
- ☐ Need for hearing aids?
- ☐ Scarlet fever
- ☐ Chronic tonsillitis
- ☐ Recurrent tonsillitis
- ☐ Peritonsillar abscess
- ☐ Recurrent ear infections
- ☐ Chronic ear fluid
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Anxiety
- ☐ Attention deficit disorder
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Autism
- ☐ Sensory disorder
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Congenital CMV
- ☐ Down syndrome
- ☐ Birth complications
- ☐ Genetic disorder
- ☐ Syndromic disorder
- ☐ Developmental delay
- ☐ Gross motor delay
- ☐ Fine motor delay
- ☐ Speech delay
- ☐ Other

Please describe in detail anything checked above:_____

_____

_____

Are immunizations up to date? YES or NO (circle) Explain delay in immunization: _____

Current Medications: (medication and dose)

_____

_____

_____

Allergies to Medications: (list type of reaction)

_____

_____

Allergies to any of the following?

- ☐ Dust
- ☐ Moldy places
- ☐ Pollen
- ☐ Iodine
- ☐ Latex
- ☐ Adhesive Tape
- ☐ Contrast dye
- ☐ Food
- ☐ Other _____

Has your child ever had allergy testing? YES or NO (circle) If yes, list details below:

Blood or Skin Testing?_____ When & Where?_____

What were the results?_____

Past Surgical History:

Surgery: Date: Name of Surgeon (if known):

Past Hospitalization History *(do not include delivery if birth was routine)*:

Dates: Reason for hospitalization: Where:

Birth History:

Full term? YES or NO (circle) If premature, how many weeks?

Intubation (breathing tube) after birth? YES or NO If YES, how long was your child intubated?

Infections during pregnancy?

Complications during pregnancy?

Complications during or shortly after delivery?

Mother's age at child's birth

History of miscarriages or childhood deaths in family?

Social History:

Who lives in your household (include siblings and their ages)?

Pets:

Daytime Childcare: ☐ At home ☐ In home daycare ☐ Daycare facility

How many children being cared for at home or daycare facility?

School:

Grade? Name of school?

Does anyone smoke in the household?

Does anyone drink alcohol in the household?

Any illicit drug use in the home?

Languages spoke at home

Any recent travel?

Has your child ever received:

- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Speech therapy
- ☐ Swallow therapy

If yes to therapy, when and for how long?

Diet:

If infant: Breast or formula fed? What formula?

How many ounces daily?

Solids? Finger foods?

Toddler and older: Concerns about diet?

Any restrictions?

Family History: Please mark if anyone in your close family has had any of the following.

	None	Mother	Father	Brother	Sister	Grandparent
Problems with Anesthesia						
Hypertension						
Heart disease						
Epilepsy						
Developmental delay						
Headaches						
Learning Disability						
ADHD						
Depression						
Obstructive Sleep Apnea						
Snoring						
Autism						
Stroke						
Migraines						
Arthritis						
Bleeding disorder						
Reflux disease						
Thyroid problems						
Hearing loss after age 20						
Hearing loss before age 20						
Cystic fibrosis						
Ulcers						
Cancer						
Diabetes						
Asthma						
Allergies						
Congenital Disorders						
Genetic Disorders						
Other						

If yes, to any of the above, please explain:_____

_____

_____

_____

Review of Systems: Check all that apply to your child.

General
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Insomnia
- ☐ Sleeping problems
- ☐ No Problems

Eyes
- ☐ Blurry vision
- ☐ Double vision
- ☐ Change in vision
- ☐ Eye pain
- ☐ Excessive tearing
- ☐ No Problems

Ears
- ☐ Hearing loss
- ☐ Ringing of ears
- ☐ Ear pain
- ☐ Ear infections
- ☐ Ear drainage
- ☐ Ear fullness
- ☐ Dizziness
- ☐ No Problems

Nose
- ☐ Congestion
- ☐ Chronic runny nose
- ☐ Difficulty breathing
- ☐ Postnasal drip
- ☐ Sneezing
- ☐ Drainage/pus
- ☐ Loss of smell
- ☐ Frequent nosebleeds
- ☐ No Problems

Throat
- ☐ Recent voice change
- ☐ Snoring
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Can't clear throat
- ☐ Chronic cough
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Loss of taste
- ☐ No Problems

Pulmonary
- ☐ Wheezing
- ☐ Choking
- ☐ Coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ No Problems

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swollen legs/ankles
- ☐ Dizziness or fainting
- ☐ Palpitations
- ☐ No Problems

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ No Problems

Genitourinary
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Difficulty wetting bed
- ☐ No Problems

Neurologic/psych
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Seizures
- ☐ Headaches
- ☐ Blackouts
- ☐ Sensory disturbances
- ☐ Motor disturbances
- ☐ Depression
- ☐ Memory difficulties
- ☐ Difficulty in school
- ☐ No Problems

Hematology
- ☐ Anemia
- ☐ Bruises easily
- ☐ Bleeds excessively after injury
- ☐ Prior transfusion
- ☐ No Problems

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Increase water intake
- ☐ No Problems

Skin/musculoskeletal
- ☐ Skin lesions/rashes
- ☐ Pigment changes
- ☐ Joint pain
- ☐ Limited motion
- ☐ Muscle weakness
- ☐ Hives
- ☐ No Problems

Allergy
- ☐ Inhalant allergy
- ☐ Contact allergy
- ☐ Environment allergy
- ☐ Food allergy
- ☐ Latex allergy
- ☐ Other:_____
- ☐ No Problems

ROCKY MOUNTAIN PEDIATRIC ENT ASSOCIATES
FINANCIAL POLICY

We would like to thank you for choosing Rocky Mountain Pediatric ENT Associates for your child's care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE

Your child is here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures. If your child sees one of our audiologists in addition to the physician or nurse practitioner, there is a separate charge for their service. Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, radiology)

MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your child's appointment two (2) business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

CHECK IN

We respect and value your time. ***If you are more than 10 minutes late for your appointment, we may need to reschedule***. We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient fashion while receiving the highest quality care.
ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 10 minutes prior** to their appointment for check in.
NEW PATIENTS: If it is your first time to our office, please arrive 15 minutes prior to your appointment time with your **paper work completed**. If the paper work is not complete, please arrive **30 minutes** prior to the appointment time.

PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service*. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered, **deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due with-in 30 days. If surgery is recommended, we collect deductibles and co-insurance prior to surgery. Payment must be received 48-hours prior to surgery.
*We do not collect co-pays at the time of service for our audiology services. If your plan applies a co-pay for these services, we will send a statement to you. Payment is expected upon receiving this statement. *Most Aetna and Cigna plans apply co-pays to both the office visit and to the audiology service.*

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff.

INSURANCE

All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility as the parent/guardian to provide accurate and timely insurance information.

INSURANCE REFERRALS:

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

Guardian/Responsible Party Signature: _____ Date: _____