

What to Bring to Your Appointment

A Simple List

1. Please bring the following cards:
 - Insurance card
 - Prescription card
 - Photo Identification for parent or guardian
2. Please bring co-pay or deductible to the visit (if applicable) (Cash / Check / Visa / MasterCard). Also, for your convenience, we participate in CareCredit. Please visit www.carecredit.com for more information.
3. Please bring any related lab test results.
4. Please bring a note from your pediatrician or family doctor summarizing the problems to be addressed at the visit.
5. Please bring x-rays, CT/MRI scans, and written reports. Please ask for films/scans to be put on a CD.
6. Please bring a complete list of medications the patient is currently taking (or has taken recently) with exact doses or bring the medications in their containers.
7. Please bring your pharmacy name and address.
8. Please bring completed new patient forms (these are the forms on the following pages of this packet). Please read forms carefully and be as accurate as possible.





Pediatric ENT Associates
PEDIATRIC
MEDICAL INFORMATION
 (Please Print)

NAME: _____
DATE : _____

MEDICATION ALLERGIES	FOOD AND ENVIRONMENTAL ALLERGIES
List all allergies to medications	List all environmental allergies
	<input type="checkbox"/> Check this box if the child has no environmental allergies
	List all food allergies
<input type="checkbox"/> Please check this box if the child has no medication allergies	<input type="checkbox"/> Check this box if the child has no food allergies

CURRENT MEDICATIONS (OVER THE COUNTER, PRESCRIPTION, AS NEEDED, AND HERBAL)
Is your child taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
List all medications

CHILDHOOD ILLNESSES		
<input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Croup <input type="checkbox"/> ✓ if recurrent <input type="checkbox"/> Infant Reflux <input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Premature Birth/How many weeks early? _____ <input type="checkbox"/> RSV <input type="checkbox"/> Febrile Seizure	<input type="checkbox"/> Other (Please List In Space Below)

CHRONIC MEDICAL PROBLEMS		
<input type="checkbox"/> ADHD <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Birth Defect <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Cancer	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Depression <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other (Please List In Space Below)

SURGERIES (WITH DATE OR AGE)	LIST ALL HOSPITALIZATIONS (WITH DATE OR AGE)

SURGERY QUESTIONS	
Did your child have any problems with anesthesia?	Please list any other surgical complications



Pediatric ENT Associates
PEDIATRIC
FAMILY AND SOCIAL HISTORY
 (Please Print)

NAME: _____

DATE : _____

FAMILY HISTORY					
Does anyone in your FAMILY (NOT THE PATIENT) have any of the following:					
Severe Reactions to Anesthesia (e.g. Malignant Hyperthermia)	Yes	No	Hearing Loss	Yes	No
Birth Defects (Cleft Lip / Palate, Down Syndrome, Birthmark)	Yes	No	Acid Reflux	Yes	No
Bleeding After Tonsillectomy	Yes	No	Allergies	Yes	No
Bleeding Problems	Yes	No	Asthma	Yes	No

IS THE PATIENT ADOPTED?
<input type="checkbox"/> Yes <input type="checkbox"/> No

ENVIRONMENT	
Are there any pets in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What Kind? _____	Who does the child live with? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
Allergy concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone who cares for the child smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No

CHILD CARE / SCHOOL	
Is the child in daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the child in school? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What Grade? ____
Is the child in special education? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the child in special therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child get regular exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	Academic concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sports / Hobbies (Please List)	

FOR INFANTS AND YOUNG CHILDREN (TO AGE 8) ONLY	
Is/Was child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, For How Long? _____	Does child use a bottle? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Is Bottle Used While Laying Down? _____
Does child use a pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, When? _____	Type of formula?
Did child pass his / her newborn hearing screening? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Check All Symptoms Which Were Ongoing During The Last 6 Months

NAME: _____

DATE: _____

REASON FOR YOUR CHILD'S VISIT TODAY :

<p>Constitutional/Sleep</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Excessive Sleepiness <input type="checkbox"/> Frequent Night Awakenings <input type="checkbox"/> Sleeping Difficulties <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss 	<p>Heart</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pains <input type="checkbox"/> Murmurs <input type="checkbox"/> Palpitations 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Behavior Changes <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Difficulty With Balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Unclear Speech
<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Itching <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Swelling 	<p>Lungs (Respiratory)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Croup <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Noisy Breathing <input type="checkbox"/> Pneumonia <input type="checkbox"/> Stops Breathing <input type="checkbox"/> Turns Blue <input type="checkbox"/> Wheezing 	<p>Psych</p> <ul style="list-style-type: none"> <input type="checkbox"/> ADHD <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Social/Behavior Problems
<p>Ears</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ear Deformity <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Ear Infections <ul style="list-style-type: none"> <input type="checkbox"/> Chronic <input type="checkbox"/> Recent <input type="checkbox"/> Ear Pain <input type="checkbox"/> Ear Sores <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Difficulty Feeding/Eating <input type="checkbox"/> Frequent Burping <input type="checkbox"/> Heartburn <input type="checkbox"/> Hiccups <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach Aches <input type="checkbox"/> Vomiting (Frequent) <input type="checkbox"/> Wet Burps 	<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problems
<p>Nose</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding <input type="checkbox"/> Congestion <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Running Nose <input type="checkbox"/> Sneezing Frequently <input type="checkbox"/> Sniffing <input type="checkbox"/> Snoring <input type="checkbox"/> Snorting <input type="checkbox"/> Trouble Breathing Through Nose 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Weakness 	<p>HEME/LYMPH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding/Bruising <input type="checkbox"/> Bleeding During/After Surgery <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Swollen Glands
<p>Mouth / Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bad Breath <input type="checkbox"/> Choking <input type="checkbox"/> Dental Problems <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Drooling <input type="checkbox"/> Gagging <input type="checkbox"/> Hoarseness <input type="checkbox"/> Something Stuck in Throat <input type="checkbox"/> Sore Throat <input type="checkbox"/> Throat Clearing <input type="checkbox"/> Throat Infections (Strep/Tonsillitis/Other) <input type="checkbox"/> Tongue Lesions/Problems 	<p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Birthmarks <input type="checkbox"/> Bruising <input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Red Dots/Spots 	<p>Allergy / Immunology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Food Sensitivities/Allergies <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hives
<p>Head/Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drainage From Neck <input type="checkbox"/> Headaches <input type="checkbox"/> Injuries <input type="checkbox"/> Masses in Neck <input type="checkbox"/> Neck Swelling <input type="checkbox"/> Unusual Head/Face Shape 		<p>Is Your Child...</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eating OK <input type="checkbox"/> Moving\Walking OK <input type="checkbox"/> Sleeping OK <input type="checkbox"/> Talking OK



Pediatric ENT Associates
PEDIATRIC DIETARY HISTORY
 (Please Print)

NAME: _____
DATE : _____

HOW MANY DAYS PER WEEK DO EACH OF THE FOLLOWING OCCUR?		WHAT TIME DOES YOUR CHILD DO THE FOLLOWING?	
Your family eats out		Eat breakfast	
Your family eats together at home		Eat lunch	
Your family eats fast food		Eat dinner	
Your child brings a school lunch		Have a bedtime snack	
Your child buys a school lunch		Go to bed	Wake up
How would you describe your child's eating habits? (Please circle one of the following choices)			
Normal		Picky	
		Overeats	

HOW OFTEN DOES THE PATIENT EAT THE FOLLOWING FOODS? (FILL IN 1 BOX PER FOOD)									
Food	Never	#Times Per Month	#Times Per Week	#Times Per Day	Food	Never	#Times Per Month	#Times Per Week	#Times Per Day
Example-Apples			2*	3**	Water				
Apples					Fish				
Bananas					Yogurt				
Pears					Cheese				
Grapes					Ice Cream				
Oranges					Eggs				
Broccoli					Chicken				
Carrots					Mints				
Corn					Hamburger				
Potatoes					Hot Dogs				
Spinach					Chicken Wings				
Tomatoes					Salami				
Ketchup					Sausage				
Pasta With Red sauce					Soda With Caffeine				
Pasta Without Red sauce					Soda Without Caffeine				
Potato Chips					Orange Juice				
Hot Sauce					Apple Juice				
Taco Sauce					Chocolate Milk				
Salsa					Milk				
Bread					Pizza				
French Fries					Grape Juice				
Cereal					Coffee				
Chocolate					Tea				
Cookies					Gatorade				
Licorice					Energy Drinks				
Chicken Fingers					Second Portions Of A Meal				
Pretzels									

*Means an apple is eaten two times per week

**Means an apple is eaten three times per day



Patient Name: _____

Date of Birth: _____

CT and MRI Requiring Prior Authorizations

Your health insurance company may require that they review and approve certain CT scans and/or MRIs before the study can be scheduled. Our office will assist with this approval process and attempt to get authorization. The insurance approval process may be difficult and take up to 7- 10 business days.

Please make sure that you have provided us with the correct insurance information so that the process will go as smoothly as possible.

We may need to involve you in this process if our request is denied. We will let you know if this occurs.

We appreciate your patience with this matter. Thank you.

Medication Requiring Prior Authorizations

Your health insurance company or prescription benefit carrier may require that they review and approve certain medication prescriptions before they can be filled at the pharmacy. Our office will assist with this approval process and attempt to get authorization. The insurance approval process may be difficult and take up to 7- 10 business days.

Please make sure that you have provided us with the correct insurance information and/or prescription benefit carrier card (example: MedCo.) so that the process will go as smoothly as possible.

We may need to involve you in this process if our request is denied. We will let you know if this occurs.

We appreciate your patience with this matter. Thank you.

Signature: _____

Date: _____