ENT Ear • Nose • Throat HEAD & NECK Specialists, P.C.

PEDIATRIC & ADULT OTOLARYNGOLOGY • HEAD & NECK SURGERY

James P. Restrepo, M.D., FACS, ECNU • Charles K. Lutz, M.D., FACS • Jeffrey S. Driben, M.D., FACS, ECNU • Scott J. Cronin, M.D. • Adam P. Vasconcellos, M.D.
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YOU MUST BRING WITH YOU:

___ **Completed** paperwork in this packet
___ Insurance Cards + Co-pay
___ If you have blood test results, CT, x-ray reports **(ACTUAL CD/Disc (CT/MRI)** related to this visit, it is your responsibility to obtain these results
___ **Current Medication List**

Radiology Department Contact Numbers:

Reading Hospital	484-628-4444
St. Joseph Hospital	610-378-2247
Diagnostic Health	610-478-8797
Surgical Institute of Reading	610-378-8800

Dear _____:

Welcome to our practice! This will confirm the appointment that has been made for you. **PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.**

If you had a recent CT scan, sleep study, MRI, x-rays or lab work related to your visit, we request that YOU pick up the CD/Disc plus the report and bring this with you the day of your visit. Any reports that your primary care physician can fax to us prior to your visit, will again be helpful. These reports are an essential part of your medical history and are critical to efficient delivery of care.

Many insurance plans require a referral. Please check with your insurance carrier if a referral is required. If so, please contact your primary care physician. **Please be sure you have obtained all the proper insurance referrals prior to your appointment. Co-payments are due at the time of service.**

New patients are asked to arrive 15 minutes prior to your appointment with all paperwork completed before you arrive to the office.

Please arrive at _____.

Your appointment time(s) are: _____ at _____AM/PM
_____ at _____AM/PM

- Patients arriving 15 minutes late or more, arriving without the actual CD/Disc, reports or referrals may be asked to reschedule
- Patients under the age of 18 must be accompanied by a parent or legal guardian.
- Appointments must be cancelled 24 hours prior to scheduled appointments. A fee of $35 will be charged for cancellations, changes and no shows.

We look forward to having you as our patient. If you have any questions prior to your appointment, please do not hesitate to contact our office at 610-374-5599.

10-10-16 revision

Acct:_____

PATIENT INFORMATION SHEET (CHILD AGE 17 AND UNDER)

Patient Name_____

Date of Birth_____

Social Security #_____Male or Female

Address:_____

_____

Phone Number_____

Parent's E-mail:_____

Referring Doctor:_____

Referring Doctor Phone_____

Family doctor/Pediatrician_____

Family doctor Phone_____

People authorized to receive Medical Information

(Name & Number)_____

_____

_____

Mother's Name_____

Address (if different):_____

_____Phone_____

Date of Birth_____

Social Security # _____

Cell Phone:_____

Father's Name_____

Address (if different)_____

_____Phone_____

Date of Birth_____

Social Security # _____

Cell Phone:_____

PRIMARY INSURANCE _____

Subscriber Name:_____

Policy ID#_____Group_____

Employer:_____

Employer Address_____

_____

Employer Phone _____

Co-Pay $_____

SECONDARY INSURANCE _____

Subscriber Name:_____

Policy ID#_____Group_____

Employer:_____

Employer Address_____

_____

Employer Phone _____

Co-Pay $_____

Has the child or any one else in the family been seen by our office before? YES – NO if yes, who?_____

Which Insurance is Primary, Mother's or Father's? (Please circle)

If the patient is a child under the age of 18, please list the guardians (who must be legal adults age 18 or older), other than the parents, who can seek medical treatment for this patient at our facility:

_____

_____

_____

HIPAA: I have read and agree with the HIPAA Privacy information.

Financial Policy: I have read and understand the financial policy.

Penn Medicine Affiliation Notice: I have read and under the Penn Medicine Affiliation Notice.

Insurance Authorization/Assignment

I hereby authorize ENT Head & Neck Specialists to release and/or obtain information to/from insurance carriers, other physicians, and/or medical facilities concerning my child's present illness/treatment and past medical history/treatment. I also hereby assign to the physicians of ENT Head & Neck Specialists all payments for medical services rendered to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature of parent_____ **Date**_____

PLEASE NOTE: Our office is not responsible for charges incurred if the updated insurance information is not provided for this patient.

Revised 9/15

PATIENT MEDICAL HISTORY **TODAY'S DATE:** _____ Acct: _____ Page 1/2

Last Name: _____ First Name: _____ MI: _____

Gender: M / F Date of Birth: _____ Marital status: _____

Occupation: _____ Race: _____ Ethnicity: Hispanic/Latino ____ Other ___

Preferred Language: English ____ Spanish ____ Other ____ **EMAIL**: _____

What is the reason for your visit? _____

Prior Testing For this Condition: YES / NO If Yes, please indicate the date of the test and what tests were performed? _____

Approximate date started: _____ Who referred you to us? _____

Who is your Family Doctor? _____

Pharmacy/Address: _____

PATIENT MEDICATION LIST **Please list all the medications (prescription & non-prescription) that you are currently taking, including Vitamins**

Medication	Strength (mg)	Time per Day	Medication	Strength (mg)	Times per Day

Are you allergic to any medication? YES / NO If Yes, please list all medication allergies and the TYPE OF REACTION: _____

Have you had allergy testing? YES / NO Date: _____ Skin? YES/NO Blood? YES/NO
Treated with allergy shots? YES / NO
List all food, contact and inhalant allergies: _____

PATIENT PAST MEDICAL HISTORY
Do you have any of the following? YES / NO If yes, please CHECK the appropriate medical condition(s).

____ Diabetes I ____ Diabetes II ____ High Cholesterol ____ High Blood Pressure
____ Asthma ____ Tuberculosis History ____ Sleep Apnea ____ Nasal allergies
____ Depression ____ Anxiety ____ History of Kidney Stones
____ Thyroid nodule ____ Thyroid dysfunction ____ History of stomach ulcer
____ Reflux (GERD) ____ Bleeding Disorder ____ Hepatitis: Type: _____
____ HIV ____ AIDS ____ History of Cancer: Type: _____
Year Diagnosed: _____

Is there a chance you are currently pregnant: ____ Yes ____ No ____ N/A

Other medical conditions or problems: _____

Height: _____ Weight: _____

Have you or anyone in your family been seen by one of our physicians in the past? YES/NO If yes, please remind us of that person's name and the physician he or she saw.

_____

Please complete page 2

Have you had a colonoscopy? ___Yes ___ No If Yes, month _____ year_____
Have you had a pneumonia vaccination? ___Yes ___ No If Yes, month _____ year_____
Have you had an influenza (flu) vaccination: ___Yes ___ No If Yes, month _____ year_____
Have you had a mammogram? ___ Yes ___ No If Yes, month _____ year_____
Have you had a pap screening? ___ Yes ___ No If Yes, month _____ year_____

Year	Surgical Procedure/Reason for Hospitalization	Reason

Have you had any serious injuries, such as head trauma, broken bones, concussion, or loss of consciousness? YES / NO
If Yes, please give the date and type of injury: _____

Do you or any member of your family have a history of problems with anesthesia? YES / NO
If Yes, please explain: _____

FAMILY HISTORY (Has any family member had any of the following: Heart Disease, Diabetes, Bleeding Disorders/problems, High Cholesterol, Allergies, Stroke, Asthma, High Blood Pressure, Hearing Loss, Cancer & what type?

Type	Family Member

Social History
Do you smoke? YES / NO If yes, amount/day: _____ Number of years: _____
If you have smoked in the past, when did you quit? _____ How much did you smoke a day? _____

Do you consume alcohol? YES / NO If Yes, please indicate amount and frequency: _____
Is there a personal history of substance abuse? YES / NO If Yes, please explain: _____

If the patient is a minor, is he or she exposed to cigarette smoke? YES / NO

Do you CURRENTLY have any of the following? YES / NO Please CHECK the medical symptom(s).

____	Blurred vision	____	Double vision	____	Ear drainage	____	Hearing loss
____	Dizziness	____	Ringing in ears	____	Ear pain	____	Nasal congestion
____	Nosebleeds	____	Postnasal drainage	____	Facial pressure	____	Sore throats
____	Hoarseness	____	Snoring	____	Chest pain	____	Irregular heart beat
____	Cough	____	Wheezing	____	Neck Mass	____	Shortness of breath
____	Stomach pain	____	Nausea	____	Headaches	____	Benign skin lesion
____	Vomiting	____	Diarrhea	____	Seizures	____	Malignant skin lesion
____	Chills	____	Sweats	____	Memory Loss	____	Sudden Weight Change
____	Difficulty or painful urinating						

Is there a personal history of hearing loss? YES / NO If yes, when was the last time your hearing was evaluated?_____ Where?_____
Do you wear Hearing Aid(s)? YES / NO How old are your current aid(s)?_____

ENT HEAD & NECK SPECIALISTS, PC
985 Berkshire Boulevard, Suite 101
Wyomissing, PA 19610
(610) 374-5599

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FINANCIAL POLICY

In the interest of good practice, we believe that it is desirable to establish a financial policy for our patients. Our goal is to avoid any miscommunication or concerns regarding financial matters, so that we may focus our energies on serving the healthcare needs of our patients. Please ask our staff if you have any questions about this. We appreciate the opportunity to participate in your health care.

- Patients are responsible for payment of all medical treatment and services provided.
  - Insurance co-pays shall be collected before being seen for each office visit.
  - Insurance co-pays and deductibles for elective surgery shall be collected prior to surgery.
  - Patients are responsible for notifying our office if you have a pre-existing clause with your insurance (this usually applies to insurance effective dates of less than 12 to 18 months).

- Our office participates with and accepts assignment with many insurance carriers.
  - As a service to our patients, we will file insurance claims for all covered services.
  - As a participating provider in a network, we will accept the insurance company's allowable payment for covered services.
  - Patients are responsible for deductibles, co-payments, non-covered services, and out-of-network services. Payment for these shall be due at the time of the visit.
  - Many health plans require a referral to be seen in our office. If this applies to your plan, you are responsible for providing our office with the appropriate authorization or referral from your primary care physician prior to your appointment.
  - Patients will not be seen without a referral if required by their insurance carrier, and may be asked to reschedule.
  - Current primary and secondary insurance cards are needed at each visit; otherwise we will need payment in full at the time of your visit.
  - Patients must advise us of the need for pre-certification by their insurance for any services.
  - Insurance plans sometimes request the patient to complete a coordination of benefits questionnaire. If requested, please complete this form and return it to your carrier. Your insurance may deny your claim if not received, and you would be responsible for payment of services in full.

- A $35 fee shall be charged for all returned checks.

- If you have a past due balance, you will be required to make payment on this prior to being seen. It is our policy that when an account is referred to our collection agency, we will terminate any future medical care until the account is satisfied.

- **Appointments must be cancelled 24 hours prior to scheduled appointments. A fee of $35 will be charged for cancellations, changes or no shows.**

Should you have any questions regarding the above, please contact our office manager. We will always be willing to discuss your insurance and/or a payment plan best suited for all concerned.

The following methods of payment are acceptable: CASH, PERSONAL CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER. FINANCING IS ALSO AVAILABLE THROUGH CARE CREDIT.

From the West (Lebanon, Sinking Spring, West Lawn)
Take Route 422 East to the Crossing Drive exit. Turn left at the bottom of the ramp onto Crossing Drive. You will pass Olive Garden on your left and Best Buy on your right, as you go through the first traffic light. At the second traffic light (Home Depot on your right), you will make a left onto Berkshire Blvd. Make an immediate right into the Wyomissing Professional Center. At the stop sign, bear left. Our building will be on the right, sitting adjacent to Papermill Road, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

From the East (Exeter, Pottstown)
Take route 422 West to the Papermill Road exit. Go straight through the first traffic light (the Tokyo Hibachi Restaurant is on your right at the corner). At the second light (Hampton Inn on the left), go straight. Take the next right driveway into the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

From the North (Kutztown, Blandon)
Take route 222 South to the Broadcasting Road exit. Turn right at the bottom of the ramp onto Broadcasting Road. Go straight through the first traffic light (the Barnes & Noble store, and Wawa are on the right). At the second light, turn left onto Papermill Road. Go straight through the 1st traffic light (Stone Hill Farms condominiums on the left), and immediately after the light, turn left into the driveway for the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

From the South (Morgantown Area)
Follow I-176 North/Morgantown Expressway. Take exit 11B toward Reading, and merge onto US-422 West. (at the fork in the highway, stay to the left for US-422, not the right - Rt 12). Take route 422 West to the Papermill Road exit. Go straight through the first traffic light (the Tokyo Hibachi Restaurant is on your right at the corner). At the second light (Hampton Inn on the left), go straight. Take the next right driveway into the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

From the Southwest (Lancaster Area)
Follow US-222 North toward Ephrata/Reading. Continue on US-222 (It merges with US422 East at this point) just past the Berkshire Mall on your left, and take the Crossing Drive exit. Turn left at the bottom of the ramp onto Crossing Drive. You will pass Olive Garden on your left and Best Buy on your right, as you go through the first traffic light. At the second traffic light (Home Depot on your right), you will make a left onto Berkshire Blvd. Make an immediate right into the Wyomissing Professional Center. At the stop sign, bear left. Our building will be on the right, sitting adjacent to Papermill Road, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.