John McClay, MD
Amy Brenski, MD

FRISCO ENT for Children

Patient Information Form

Patient's Legal Name: _____ Preferred Name: _____

Home Address: _____ Date of Birth: _____

City/ State: _____ Zip Code: _____ Gender: **Male | Female**

Parental/ Guardian Information

Mother's Name: _____

Date of Birth: _____

Home Address: _____

City/ State: _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email Address (for appointment reminders):

_____

Employer: _____

Father's Name: _____

Date of Birth: _____

Home Address: _____

City/ State: _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email Address (for appointment reminders):

_____

Employer: _____

Insurance Information

Primary Insurance: _____

ID Number: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

ID Number: _____

Group Number: _____

Phone Number: _____

Emergency Contact

Person to Contact (Other than Parent): _____

Relationship to Patient: _____ Phone Number: _____

Physician Information

Primary Care: _____ Phone Number: _____

Location: _____

Referring Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Location (Street/ City): _____

Do you have any other children that have been seen in our practice? ☐ **YES** ☐ **NO**

If **YES**, please provide their names: _____

11445 Dallas Parkway
Suite 240
Frisco, TX 75033

www.FriscoENTforChildren.com

Phone: 214.494.4150
Fax: 972.315.9053

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Medical History Form – New Patient

Patients' Name: _____ Date of Birth: _____
Primary Care Physician: _____
Referring Physician: _____
Your relationship to the patient: ☐ Parent ☐ Legal Guardian ☐ Grandparent
☐ Other (please specify) _____
What medical problems are we seeing your child for today? _____

_____

_____

Have you previously seen either of our doctors at a different office? **NO | YES** _____

Allergies

Is your child allergic to **LATEX**? **NO | YES**
Does your child have any food allergies? **NO | YES** _____
Does your child have any **MEDICATION ALLERGIES**? **NO | YES**
If **YES**, which medication(s) and what type of reaction? _____

_____

Medications

Is your child currently taking any medications? **NO | YES**
If **YES**, please list the medications below.

Medication	Dose	Frequency	Date Started

Has your child recently had …?
☐ Ear infections ☐ Tonsillitis/ Strep throat ☐ Sinus infections ☐ Nosebleeds
Total number of episodes _____ in _____ (amount of time).

If applicable, please check the antibiotics given to treat your child:
☐ Amoxicillin ☐ Augmentin/ Amox-Clauv ☐ Bactrim/ Sulfa ☐ Biaxin/ Clarithromycin
☐ Cedax/ Ceftibuten ☐ Ceftin/ Cefuroxime ☐ Cefzil/ Cefprozil ☐ Cleocin/ Clindamycin
☐ Erythromycin ☐ Omnicef/ Cefdinir ☐ Suprax/ Cefixime ☐ Vantin/ Cefpodoxime
☐ Zithromax/ Azithromycin ☐ Rocephin/ Ceftriaxone Shot
☐ Other: _____

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Birth History

☐ Full Term ☐ Premature How many weeks premature? _____
☐ Vaginal ☐ C-Section

Were there complications? **NO | YES** _____
Did your child ever stay in the NICU? **NO | YES**, how long? _____
Has your child ever required a breathing tube? **NO | YES**, how long? _____
Was oxygen required? **NO | YES**
Were IV Antibiotics required? **NO | YES**
Newborn hearing screen? **NO | PASS | FAIL: BILATERAL \ RIGHT \ LEFT**

Social History

	NO	YES		NO	YES
Does anyone in the household smoke?	☐	☐	Does your Child breast feed?	☐	☐
Are your child's immunizations up to date?	☐	☐	Does your Child use a bottle?	☐	☐
Does your child attend daycare?	☐	☐	Does your Child use a pacifier?	☐	☐
Does your child attend school?	☐	☐	Does your Child suck their thumb/ fingers?	☐	☐

If **YES**, what grade? _____

Who lives with you? _____

Family History

Does anyone in your family have a history of any of the following?

	NO	YES		NO	YES
Anesthesia difficulties (more than nausea and vomiting)	☐	☐	Excessive bleeding with childbirth	☐	☐
Bleeding disorder	☐	☐	Excessive bleeding with surgery	☐	☐
Early hearing loss (<40 years old)	☐	☐	Thyroid disorder	☐	☐
Easy bruising	☐	☐	Kidney disease	☐	☐
Sudden Death	☐	☐	Dialysis	☐	☐
Goiter	☐	☐	Cystic Fibrosis	☐	☐

If you answered **YES**, what is their relationship to your child and what is the history?

_____
_____
_____
_____
_____
_____

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Medical History

Does your child ***have*** or ***ever had*** any of the following?

	NO	YES		NO	YES
Aspiration	☐	☐	Heart Disease	☐	☐
ADHD or ADD	☐	☐	Heart Murmur	☐	☐
Asthma	☐	☐	Hydrocephalus	☐	☐
Bleeding problems	☐	☐	Immune Deficiency	☐	☐
Cancer	☐	☐	Kidney disease	☐	☐
Chronic Sinusitis	☐	☐	Liver disease	☐	☐
Cleft Lip	☐	☐	Nasal Polyps	☐	☐
Cleft Palate	☐	☐	Neurological disorder	☐	☐
Cystic Fibrosis	☐	☐	Recurrent Pneumonias	☐	☐
Depression/ Anxiety	☐	☐	RSV	☐	☐
Diabetes	☐	☐	Seizure disorder	☐	☐
Failure to Thrive	☐	☐	Swallowing Problems	☐	☐
Gastroesophageal Reflux (GERD)	☐	☐	Syndrome_____	☐	☐
Gastrointestinal Disorders	☐	☐	Other_____	☐	☐

Please describe **Other** and **YES** answers from above:

_____

_____

Surgical History

Has your child ***ever had***?

	NO	YES		NO	YES
Heart Surgery	☐	☐	Ventriculo-Peritoneal Shunt	☐	☐
Heart Valve Replacement	☐	☐	Does your child require antibiotic prophylaxis for surgery?	☐	☐

Please list ***all*** surgical procedures your child has had.

Procedure	Date	Surgeon/ Location
Ear Tubes		
Adenoidectomy		
Tonsillectomy		
Tonsils and Adenoids (T&A)		
Bronchoscopy		
Laryngoscopy		
Airway Reconstruction		
Sinus Surgery		
Balloon Sinuplasty		
Neck Mass Excision		
Other		
Other		
Other		
Other		
Other		

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Does your child have any of these symptoms today?

General
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Body aches
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of appetite
- ☐ General weakness
- ☐ Daytime sleepiness

Ear, Nose & Throat
- ☐ Pulling at ears
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Pressure in ear(s)
- ☐ Ear swelling
- ☐ Itchy ear
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Balance problems
- ☐ Nasal obstruction
- ☐ Nasal congestion
- ☐ Sneezing
- ☐ Runny nose
- ☐ Itchy nose
- ☐ Postnasal drip
- ☐ Nose bleeds
- ☐ Enlarged tonsils
- ☐ Snoring
- ☐ Mouth breathing
- ☐ Sore throat(s)
- ☐ Bad breath
- ☐ Throat clearing
- ☐ Pain with swallowing
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Neck pain
- ☐ Neck swelling
- ☐ Thyroid mass
- ☐ Mouth breathing
- ☐ Throat infections
- ☐ Teeth grinding

Eyes
- ☐ Eye discharge
- ☐ Eye irritation
- ☐ Eye pain
- ☐ Change in vision
- ☐ Redness of eye(s)
- ☐ Dryness of eye(s)
- ☐ Burning of eye(s)
- ☐ Watery eyes
- ☐ Swelling of eyelid(s)
- ☐ Itchy eyes

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beats
- ☐ Rapid heart rate
- ☐ Syncope/ Fainting
- ☐ Gasping at night
- ☐ Requires head elevation for sleep
- ☐ Shortness of breath with exertion
- ☐ Lower extremity edema
- ☐ Blue spells
- ☐ Lightheadedness
- ☐ Other heart problems

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Nighttime cough
- ☐ Productive cough
- ☐ Snoring
- ☐ Stridor/ Noisy breathing
- ☐ Aspiration
- ☐ Pneumonia(s)
- ☐ Croup
- ☐ Hoarseness
- ☐ Obstructive sleep apnea

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Swallowing problems
- ☐ Heartburn
- ☐ Excessive belching
- ☐ Abdominal pain
- ☐ Frequent spit ups
- ☐ Blood in vomit
- ☐ Blood in stool

Genitourinary
- ☐ Bed wetting
- ☐ Urinary reflux
- ☐ Urinary tract infection
- ☐ Kidney problems

Skin
- ☐ Skin rash
- ☐ Skin itching
- ☐ Skin dryness
- ☐ Acne

Neurologic
- ☐ Swallowing problems
- ☐ Incoordination
- ☐ Difficulty concentrating
- ☐ Memory difficulties
- ☐ Speech difficulties
- ☐ Seizures
- ☐ Trouble sleeping
- ☐ Loss of consciousness

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Muscular weakness

Endocrine
- ☐ Constipation
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Obesity
- ☐ Weight gain
- ☐ Weight loss
- ☐ Excessive sweating
- ☐ Diabetes

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Behavior problems
- ☐ Suicidal ideation
- ☐ Excessive anger
- ☐ Irritability
- ☐ Attention problems

Blood-Immune
- ☐ Lightheadedness
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Large lymph node(s)
- ☐ Nose bleeds
- ☐ Gum bleeding
- ☐ Cancer

Allergic-Immunologic
- ☐ Sinus allergy symptoms
- ☐ Allergic dermatitis
- ☐ Frequent illnesses
- ☐ Food allergies
- ☐ Hives
- ☐ Anaphylaxis
- ☐ Immune deficiency

Name: _____

Signature: _____

Date: _____

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FRISCO ENT for Children

Authorization for Release of Protected Health Information

By signing below, I authorize Frisco ENT for Children, PLLC to **RECEIVE | DISCLOSE** (circle one or both)

protected health information about my child **TO | FROM** (circle one)

Physician/ Clinic/ Hospital/ Parent/ Other: _____

Address: _____

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose or reason for this is as follows:

_____

_____

Please initial each section to be released.

_____ Entire Medical Records

_____ Office Visit Note

_____Labs

_____ Audiology

_____ Other _____

Will the patient be returning to Frisco ENT for Children PLLC? **YES | NO**

If NO, why have you chosen to leave? _____

Name of Patient	Date of Birth
_____	_____
_____	_____
_____	_____

Fees to Copy Records

These fees are regulated by the Texas Medical Board, $25 for the first 20 pages of medical records copied, $0.50 for each additional page plus postage. There is no charge for records sent to another physician.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer: Dianna Moore. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 12 months from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign authorization. I need not sign the form in order to assure treatment. I understand that I may inspect or obtain a copy of information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand that a copy of facsimile of this authorization is valid as the original. I understand that I must provide proof of my identity when submitting this request.

_____	_____	_____
Parent/ Guardian Signature	Date	Relationship to Patient
_____	_____	
Print Name	Phone	

Frisco ENT for Children, PLLC and their employees or agents are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized.

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FINANCIAL POLICY

Payment is due at the time of your appointment. We gladly accept cash, check, M/C, Visa and Discover. If we are a contracted provider with your insurance company, we will file the insurance claim for your child. However, any co-pay, co-insurance or deductible must be paid prior to your child seeing the physician and/or prior to any surgery being performed. Please keep in mind that your insurance policy is a contract between **you** and **your** insurance company. If your child's claim for services is denied as a non-covered service or any other reason, you will be responsible for payment of those services.

If you have an insurance plan that requires a referral ***PRIOR*** to your child's visit, you are responsible for obtaining that referral. The referral must either be presented at the visit or sent to this office prior to the visit. If you arrive for your child's appointment and have not verified that your referral has been completed, you will need to either reschedule the visit to a date that allows for referral to be obtained or you will be asked to pay for your child's visit in full. Frisco ENT for Children is unable to obtain referrals from your insurance company as they do not allow us to do so.

Some in-office procedures are necessary for the evaluation and management of your child's care. These include, but are not limited to, the use of a microscope, endoscope and audiology testing. These procedures are sometimes applied to deductibles and co-insurance as they are not covered under the office visit co-pay. You are responsible for paying the allowed contracted amount for these services.

If we are not contracted with your insurance, you will be responsible for the payment in full on the day services are provided. In the case of surgery, you are responsible for payment in full **prior** to your child's procedure. A discount for cash payment may be applied. The filing of any insurance claim for your personal reimbursement will be your responsibility. We will gladly supply the required information so that you may file your child's claim.

For our patients that do not have insurance, payment is due in full at the time services are provided. A discount may be applied. A detailed receipt will be available to you for your records.

There is a $25 returned check charge for any check returned by your financial institution. Any returned check amount and fees associated with that check, must be paid in full prior to your child's return to our office for services. We may not accept personal checks from you in the future.

Appointments must be cancelled or rescheduled at least 24 hours in advance. However, if your child's appointment is on a Monday, you must cancel or reschedule by the Friday before the appointment. We may charge a missed appointment fee of $35. Please note that this fee is not covered by the insurance. Please help us to serve you better by keeping your child's scheduled appointment.

Your child may be dismissed from the practice if you fail to meet your financial responsibilities. If we have to use a collection agency to bring your child's account up-to-date you will be responsible for all charges, including those incurred to collect the amount owed. Before your child can return to our office, your account must be paid in full.

Thank you for choosing us as your child's health care provider. We are committed to the success of your child's treatment.

_____ _____

Parent/ Guardian Signature Date

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Surgery Disclosure

Dear Parents,

In the event that you have to schedule a surgical procedure with Dr. John McClay or Dr. Amy Brenski for your child, you will be given pertinent information that needs your review. Literature concerning instructions for post-operative care, information on anesthesia and a brochure with information concerning the surgical facility that you have chosen will all be included.

Our pre-certification department will contact your insurance company the week before the surgery to make sure that all requirements are met. **If a co-insurance, co-payment or deductible is due, we expect payment 48 hours in advance of your child's scheduled procedure.** The amount collected is an ***estimate*** of what you may owe. Your insurance company may process your claim differently from what we expect. In some cases, there may be a change in the procedure performed and the charge may be different than what was originally quoted. If this happens, you will receive a statement from our office which should be paid in a prompt manner.

The surgical facility and the anesthesia group are both separate entities from us. They are responsible for collecting monies for their part of your child's procedure(s). They are also responsible for obtaining their own pre-certification. Please do not contact our office if you receive a statement from someone other than Frisco ENT for Children. It is imperative that you contact the surgical facility that you have chosen to discuss their billing and collection practices ***before*** your child's procedure(s). You will also need to contact the anesthesia group ***prior*** to your child's surgery to discuss their billing and collection methods. Please call your insurance company a few days ***before*** the surgery to verify that all pre-certifications have been obtained.

If your child becomes ill near the date of the surgery, please contact our office immediately. We will instruct you if further follow-up is needed here at our office or if you need to contact your child's pediatrician. It is possible that the surgery may need to be rescheduled.

The surgical facility will contact you **after 3 pm the day before your child's scheduled procedure(s)** to give you instruction on preparations for the upcoming procedure(s). The anesthesiologist may or may not contact you as well.

In the course of your child's treatment with Dr. John McClay or Dr. Amy Brenski, you may be given the option of having surgical services performed at Cook Children's Pediatric Surgery Center or Forest Park Medical Center Frisco. One or both physicians have an ownership interest in these facilities, and, as a result, they may financially benefit from using this facility in the form of dividends or distributions. Please understand that you have a choice of which healthcare facility to use. We welcome any questions regarding the financial relationship between the doctors and the above mentioned surgery centers.

_____ _____

Parent/ Guardian Signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

USE AND DISCLOSURES

Treatment – Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations – Your health information may be used as necessary to support the day-to-day activities and management of Frisco ENT for Children, PLLC. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization – Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment reminders – Your health information will be used by our staff to send you appointment reminders.

Information about treatments – Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising – Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☑ Please do not use my information for fund raising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Frisco ENT for Children, PLLC Duties – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information – You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Dianna Moore, Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints – If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dianna Moore
ENT for Children, P.A.
783 N Denton Tap Rd., Suite 200
Coppell, Texas 75019

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person – The name and address of the person you can contact for further information concerning our privacy practices is:

Dianna Moore
ENT for Children, P.A.
783 N Denton Tap Rd., Suite 200
Coppell, Texas 75019
(972) 745-8400

Effective Date – This notice is effective on or after **October 1, 2006.**

Parent signature: _____ **Date:** _____