DANNY WONG, MD, PA
4201Garth Rd. Ste. 321
Baytown, TX 77521

PEDIATRIC PATIENT INFORMATION

DATE_____

Last name _____First name _____MI____ Social Security#_____

Date of birth _____ Patient lives with: ☐ Mother ☐ Father ☐ other: _____ SEX: ☐ M ☐ F

PARENT/GUARDIAN INFORMATION

Mother / Guardian (If guardian list your relationship _____)

Name _____

Address _____
City_____State_____Zip_____

Home phone _____
Work phone _____
Cellular phone _____

Employed By _____
Date of Birth_____
Social Security #_____

Father / Guardian (If guardian list your relationship _____)

Name _____

Address _____
City_____State_____Zip_____

Home phone _____
Work phone _____
Cellular phone _____

Employed By _____
Date of Birth_____
Social Security # _____

Person responsible for account (insurance guarantor) ☐ Mother ☐ Father ☐ other:_____

INSURANCE INFORMATION

Insurance Company Name _____ ID#_____
Group #_____ Insurance Company phone _____

Does the patient have secondary insurance coverage? ☐**Yes** ☐ **No** Insurance Name _____

IN CASE OF EMERGENCY NOTIFY (other than previously listed parent or guardian)

Name_____ Relationship_____ Phone _____

How did you learn of our practice?_____
Name of pediatrician/family physician_____
Did he/she refer you to Dr Wong? ☐**Yes** ☐ **No**
Pharmacy name_____ Phone_____

I HAVE READ THE DANNY WONG, M.D., P.A. FINANCIAL POLICY ON THE REVERSE SIDE OF THIS FORM, AND I AGREE TO BE BOUND BY ITS TERMS. I UNDERSTAND THAT BY SIGNING THIS FORM I AM ACCEPTING FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR THE ABOVE LISTED PATIENT.

_____ _____ _____
SIGNATURE OF PARENT OR GUARDIAN RELATION TO PATIENT DATE

Financial Policy of Danny Wong M.D.

We at DANNY WONG M.D., P.A. are committed to providing you with the best possible medical care. If you have medical insurance, we will endeavor to help you receive your maximum allowable benefits. In order to achieve theses goals, we need your assistance and your understanding of our financial policy. Please read the following outline carefully and if you have any questions do not hesitate to ask.

Payment for services is due at the time services are rendered unless special arrangements have been made in advance. If you have medical insurance coverage, we will file any and all services rendered to your primary insurance only. You will be responsible for all co-payments, deductibles and/or co-insurance amounts at the time services are rendered. We accept cash, checks, VISA and MASTERCARD. We utilize POSITIVE PAY CHECK SYSTEMS in which all checks presented as payment will be submitted electronically and the amount of the check is electronically debited from your account at the time the check is presented. If your check is denied for payment, an alternate form of payment must be used. There is a $25.00 charge for all returned checks.

Due to the increasing number of patients who "no show" for appointments a $50.00 fee will be charged for broken appointments. We ask that patients kindly give 24 hour notice if unable to attend a scheduled appointment to avoid this fee.

You must realize however that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract
- Our fees are generally considered to fall within the acceptable range by most companies, and therefore covered up to the maximum allowance determined by each carrier. This applies only to companies with a percentage (such as 50% or 80%) of UCR. UCR is defined as usual, customary and reasonable by most companies. This statement does not apply to insurance companies who reimburse based on an arbitrary "schedule" of fees which bears no resemblance to the current standard and cost of care in this area.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Filing of insurance claims is a courtesy that we extend to our patients; however, all charges are ultimately your responsibility from the date the services are rendered. We realize that temporary financial difficulties may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have questions about the above information outlining the financial policy of DANNY WONG M.D., P.A. or regarding your insurance coverage, please do not hesitate to ask. We are here to help!

By signing on the reverse side, I understand and agree to the financial policy of DANNY WONG M.D., P.A., and I assign to DANNY WONG M.D., P.A. the benefits payable by my insurance company for the treatment rendered to myself and/or dependants. Your signature also authorizes the release of any and all information to submit claims for benefits, services rendered or services to be rendered for yourself and/or dependants without obtaining your signature on each and every claim to be submitted. Your signature also acknowledges your understanding that you are ultimately responsible for all charge not covered by your insurance company.

In Office Surgical Procedures

There are some procedures that are done in the office that are considered "surgery" by the insurance carriers including Medicare. Some examples of these "surgical procedures" include removal of wax and various uses of scopes within this office, including flexible laryngoscopy, nasal endoscopy, and nasopharyngoscopy. These procedures are often an additional charge to the office visit, and may appear on your bill as such. Surgical procedures may go toward your deductible and may involve more than a co-pay, if your insurance warrants.

I understand that office procedures are an additional surgical procedure and agree to the financial responsibility for procedures if performed.

Parent/guardian signature _____ Date _____

Danny Wong MD, PA

Patient Name: _____ Date of Birth: _____

Authorization For Release of Protected Health Information

Please list anyone who you would like to have access to your medical information. You do not need to list your referring physician but any others (example: family members, friends, employers, caretakers). This information may include your diagnosis, treatment plan, prognosis, test results, appointments and/or billing information.

If you do not want your information to be released to anyone, please leave blank.

Name: _____ Relationship _____
Phone: _____

Name: _____ Relationship _____
Phone: _____

Name: _____ Relationship _____
Phone: _____

****

It is often necessary to release some personal, health and/or diagnostic information for purposes such as: to schedule diagnostic tests/surgical procedures, to contact you in regards to scheduled appointments by US mail or telephone, to keep your referring physician informed of your condition, and/or to refer you to another physician or facility for services. Please mark the appropriate box below if you do or do not authorize your information to be released in the manner stated above.

☐ Yes, I do agree ☐ No, I do not agree

****

Acknowledgement of Notice Privacy Practices

By signing below I am acknowledging that I have reviewed and agree to this office's Notice of Privacy Practices (posted in waiting room, exam rooms, and available if you would like a copy for your records) which explains how my medical information will be used and disclosed. I also understand that I may revoke this authorization, in writing, at any time by contacting the HIPPA Privacy Officer at this office.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

ENT PATIENT HEALTH HISTORY **DATE _____**

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out <u>every</u> item.**

Full Name _____ Date of birth _____Age _____

☐**Male** ☐**Female- Could you possibly be pregnant?** ☐**Yes** ☐ **No** **Are you breastfeeding?** ☐**Yes** ☐ **No**

What is the main reason you are seeing the doctor today?_____
_____
_____
_____

REVIEW OF SYSTEMS: check any symptoms you have recently experienced.

CONSTITUTIONAL
☐ chills
☐ fatigue
☐ fever
☐ weight loss
☐ weight gain
☐ night sweats

HEENT
☐ blurred vision
☐ choking on liquids
☐ choking on solids
☐ diplopia (double vision)
☐ dizziness
☐ drooling
☐ dysphagia (difficulty swallowing)
☐ ear drainage
☐ hoarseness or change in voice
☐ mouth ulcers
☐ otalgia (ear pain)
☐ pharyngitis
☐ tinnitus (ringing in ear)
☐ vertigo
☐ visual changes
☐ hearing loss
☐ lump in throat
☐ nosebleeds
☐ decrease sense of smell or taste
☐ nasal or facial pain
☐ pressure around nose
☐ nasal congestion
☐ runny nose
☐ postnasal drainage
☐ headaches
☐ bad breath
☐ throat pain or sore throat
☐ easy bruising
☐ masses (lumps) in neck

RESPIRATORY
☐ apnea during sleep
☐ shortness of breath
☐ snoring
☐ wheezing
☐ non-productive cough
☐ productive cough
☐ coughing up blood

CARDIOVASCULAR
☐ chest pain
☐ heart murmur
☐ palpitations
☐ mitral valve prolapse

GASTROINTESTINAL
☐ abdominal pain
☐ constipation
☐ diarrhea
☐ heartburn or indigestion
☐ vomiting

GENITOURINARY
☐ changes in urine color
☐ dysuria (painful urination)
☐ urinary frequency

METABOLIC/ENDOCRINE
☐ cold intolerance
☐ heat intolerance
☐ increased thirst

NEUROLOGICAL
☐ difficulty falling asleep
☐ difficulty staying asleep
☐ excessive daytime sleepiness
☐ non-restorative sleep
☐ numbness in extremities
☐ syncope (fainting)
☐ tingling
☐ tremor
☐ weakness

PSYCHIATRIC
☐ anxiety
☐ depression
☐ hallucinations

OTHER
_____
_____

NAME_____

PAST HEALTH HISTORY: Check conditions <u>you</u> have or have had in the past.

☐ AIDS ☐ alcoholism ☐ anemia ☐ arthritis ☐ asthma ☐ birth disorder ☐ bleeding disorders ☐ bronchitis ☐ cancer, type_____ ☐ chronic infection ☐ congestive heart failure ☐ COPD ☐ coronary artery disease ☐ CVA (stroke) ☐ depression ☐ diabetes ☐ emphysema	☐ ENT Syndromes ☐ GERD ☐ glaucoma ☐ Grave's disease ☐ headaches ☐ heart disease ☐ hepatitis ☐ high blood pressure ☐ high cholesterol ☐ hyperthyroidism ☐ hypothyroidism ☐ HIV positive ☐ kidney disease ☐ liver disease ☐ lupus ☐ migraine headache ☐ mononucleosis	☐ multinodular goiter ☐ multiple sclerosis ☐ mumps ☐ myocardial infarction (heart attack) ☐ otosclerosis ☐ prostate problems ☐ psychiatric care ☐ seizure disorder ☐ sleep apnea ☐ stomach ulcer ☐ tinnitus ☐ tonsillitis ☐ tuberculosis ☐ vertigo ☐ other _____ ☐ other _____ ☐ No medical conditions

FAMILY HISTORY

Check the box if you have a <u>family</u> history of any of the following conditions.
If someone in your family has a condition, list familial <u>relationship</u> (father, mother, brother, etc.)

☐ Allergies_____
☐ Asthma _____
☐ Autoimmune disease (arthritis, lupus, MS, etc.) _____
☐ CAD (Coronary artery disease) _____
☐ Cancer (list person and type) _____
☐ Cleft lip/ palate _____
☐ CVA (stroke) _____
☐ Depression _____
☐ Developmental delay _____
☐ Diabetes _____
☐ GERD (reflux) _____
☐ Hearing disorder _____
☐ Hematological disorder (anemia, bleeding disorders, etc.) _____
☐ Hyperlipidemia (high cholesterol/triglycerides) _____
☐ Hypertension _____
☐ Migraines _____
☐ Obesity _____
☐ Chronic otitis media _____
☐ Otosclerosis _____
☐ Renal disease _____
☐ Seizure disorder _____
☐ Sickle cell disease _____
☐ Sleep apnea _____
☐ Thyroid disorder _____
☐ Other _____
☐ No family history of medical conditions

Have you recently been hospitalized for a medical problem? ☐ Yes ☐ No If **yes**, list the reason for admission and the date.

_____

NAME_____

CURRENT MEDICATIONS:
Are you taking **ANY** kind of medication now? (Including prescription, over-the-counter or herbal medicine) ☐Yes ☐ No
(If **yes**, please list below *include dosages*.)

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES:
Are you allergic to any medications? ☐Yes ☐ No (If **yes**, please list below.)

Medication Name	Type of Reaction	Severity (mild to severe)

Are you allergic to anything in the environment such as pollens, dust, food, etc.? ☐Yes ☐ No If **yes**, please indicate what you are allergic to. _____

SURGERIES
Have you ever had surgery? ☐Yes ☐ No If **yes**, list any surgeries and when they were done.

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐Yes ☐ No If **yes**, please list what sort of problems._____

SOCIAL HISTORY:
What is or was your occupation? _____ Check here if you are retired ☐

Ethnicity _____ Do you use caffeine? ☐Yes ☐ No Type _____Usual amount _____

Do you consume **alcohol**? ☐Yes ☐ No If **yes**, please list: Type of Alcohol_____ Amount per day _____

Have you **ever** used **tobacco** in any form? ☐Yes ☐ No Do you **currently** use **tobacco** in any form? ☐Yes ☐ No

Are you exposed to second hand smoke? ☐Yes ☐ No If you have used or currently use tobacco please complete the following: Type of Tobacco _____ Amount per day: _____ Ever tried to quit ☐Yes ☐ No

Total number of years of use _____ Year Quit _____ Longest tobacco free _____ Relapse reason _____

I certify that that information provided is **true** and **accurate** to the best of my knowledge.

Parent/Guardian Signature _____