Lucian Sulica, M.D.

Date of visit: ___/___/____

Patient's Name: _____

Date of Birth: ___/___/____ **Age:** _____ **Weight:** _____ **Height:** _____

Reason for the visit: _____

Occupation/Employer: _____

Marital Status: _____ **Name of spouse/Significant other:** _____

Children's Names & Birthdates (if applicable): _____

Please List all prior major illnesses/surgeries (with years):

Operations: 1. _____ 2. _____ 3. _____

Hospitalizations: 1. _____ 2. _____ 3. _____

Illnesses/Injuries: 1. _____ 2. _____ 3. _____

Family History (check)? ☐ Heart disease ☐ Diabetes ☐ Cancer ☐ Other _____

Which family member?: _____

Do you drink alcohol? ☐ No, never ☐ No, but I used to ☐ Yes How many drinks? ___ day/week

Do you smoke? ☐ No, never ☐ No, I quit in _____ ☐ Yes Packs per day? _____x ____years.

Do you use illicit drugs? ☐ No, never ☐ No, but I used to ☐ Yes Which drug?_____

Have you experienced any of the following? (Circle Y or N or N/A)

Constitutional

weight gain/loss (>15lbs)	Y	N
constant night sweats	Y	N

Eyes

double vision	Y	N
glaucoma	Y	N

Ear/Nose/throat

hearing loss	Y	N
ear pain	Y	N
ringing in ears	Y	N
balance problems	Y	N
hearing aid	Y	N
difficulty breathing	Y	N
nosebleeds	Y	N
nasal drainage	Y	N
sinus problems	Y	N
snoring	Y	N
voice changes	Y	N

Cardiovascular

heart attack	Y	N
↑ blood pressure	Y	N
heart murmur	Y	N

Gastrointestinal

chronic diarrhea	Y	N
heartburn	Y	N

Endocrine

diabetes	Y	N
thyroid disease	Y	N
autoimmune disease	Y	N

Neurologic

headaches	Y	N
seizures	Y	N
stroke	Y	N

Hematology

bruise easily	Y	N
anemia	Y	N

Genitourinary

frequent urination		Y	N
prostate problems	n/a	Y	N

Skin

past skin cancer	Y	N
past radiation therapy	Y	N

Musculoskeletal

arthritis		
chronic back pain	Y	N

Respiratory

asthma/emphysema	Y	N
chronic cough	Y	N
tuberculosis	Y	N

Psychiatric

anxiety	Y	N
depression	Y	N
sleep apnea	Y	N

If you answered YES to any of the above, please explain: _____

_____

_____

_____

Reviewed by: _____

Lucian Sulica, M.D.

IF THE MAIN REASON FOR YOUR VISIT IS A VOICE PROBLEM, PLEASE FILL OUT THE FOLLOWING TWO PAGES.

Patient's Name: _____

Were you referred by a physician? (YES / NO) If yes, whom: _____

When did the problem start? _____ **Did it start suddenly or gradually?** _____

Was there an inciting incident? (YES / NO) If yes, please explain: _____

_____

Have you had this problem before? (YES / NO) If yes, please explain when, how often, and if/how it resolved: _____

_____

Are you a performer? (YES / NO) If yes: Professionally Full-time student Part-time student Hobby

Do you have an important voice-related event coming up? Y N If yes, when: _____

Have you missed work due to your problem? Y N **Have you been intubated recently?** Y N

HAVE YOU SEEN ANOTHER PHYSICIAN FOR YOUR VOICE COMPLAINT? Please circle one (YES / NO)

If YES, please fill out a separate section below for each physician you have seen previously.

Type of Physician (Circle one below) Physician's Name Date of Visit(s) Date of Visit(s)

ER / ENT / Primary Care / Other _____ ____/____/____ ____/____/____

Diagnosis(es) given (with dates): _____ OR I don't recall

_____

What tests were done for diagnosis? Laryngoscopy Stroboscopy EMG CT/MRI Esophagoscopy OR I don't recall

Other tests: _____

What treatments were prescribed? Steroids Antibiotics Antacids Voice rest/therapy OR I don't recall

Other treatments: _____

What procedures were done for treatment? Office surgery Surgery in the operating room OR I don't recall

Other procedures: _____

Type of Physician (Circle one below) Physician's Name Date of Visit(s) Date of Visit(s)

ER / ENT / Primary Care / Other _____ ____/____/____ ____/____/____

Diagnosis(es) given (with dates): _____ OR I don't recall

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What tests were done for diagnosis? Laryngoscopy Stroboscopy EMG CT/MRI Esophagoscopy OR I don't recall

Other tests: _____

What treatments were prescribed? Steroids Antibiotics Antacids Voice rest/therapy OR I don't recall

Other treatments: _____

What procedures were done for treatment? Office surgery Surgery in the operating room OR I don't recall

Other procedures: _____

Patient's Name: _____

Type of Physician (Circle one below) Physician's Name Date of Visit(s) Date of Visit(s)

ER / ENT / Primary Care / Other _____ ____/____/____ ____/____/____

Diagnosis(es) given (with dates): _____ OR I don't recall

_____

What tests were done for diagnosis? Laryngoscopy Stroboscopy EMG CT/MRI Esophagoscopy OR I don't recall

Other tests: _____

What treatments were prescribed? Steroids Antibiotics Antacids Voice rest/therapy OR I don't recall

Other treatments: _____

What procedures were done for treatment? Office surgery Surgery in the operating room OR I don't recall

Other procedures: _____

Please answer each of the following questions, even if your answer is "never" or "no problem."

VHI-10: These are statements that many people use to describe their voices and the effects of their voices on their lives.

(Circle the response that indicates how frequently you had the same experience within the past month)

0 = Never
1 = Almost Never *3 = Almost Always*
2 = Sometimes *4 = Always*

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict my personal and social life.	0	1	2	3	4
I feel left out of conversation because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problems upset me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4

For clinician use: Total: _____/ 40 Severity: _____

IF YOU ARE A PERFORMER, please answer each of the following questions, even if your answer is "never" or "no problem."

SVHI-10: These are statements that many people use to describe their singing and the effects of their singing on their lives.

(Circle the response that indicates how frequently you had the same experience within the past month)

0 = Never
1 = Almost Never *3 = Almost Always*
2 = Sometimes *4 = Always*

It takes a lot of effort to sing.	0	1	2	3	4
I am unsure of what will come out when I sing.	0	1	2	3	4
My voice "gives out" on me while I am singing.	0	1	2	3	4
My singing voice upsets me.	0	1	2	3	4
I have no confidence in my singing voice.	0	1	2	3	4
I have trouble making my voice do what I want it to do.	0	1	2	3	4
I have to "push it" to produce my voice when singing.	0	1	2	3	4
My singing voice tires easily.	0	1	2	3	4
I feel something is missing in my life because of my inability to sing.	0	1	2	3	4
I am unable to use my "high voice."	0	1	2	3	4

For clinician use: Total: _____/ 40 Severity: _____

Additional Comments: _____

Weill Cornell Medical College

NewYork-Presbyterian Hospital
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Department of Otolaryngology-Head & Neck surgery

Referring Physician, Medication and Pharmacy Information Form

Patient's Name: _____ Date: _____

The name and address of your Internist or Referring doctor:

Physician's Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Medications:

Do you have any allergies to Medications? No Yes (please list):_____

Please list all medications that you are taking (including over-the-counter medication such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pills, etc):

Medication	Dosage(mg, teaspoons, etc)	Frequency

Vaccination History:

Date of most recent Flu shot (ages 6 months +)_____ **Date of most recent Pneumonia shot (ages 65+)**_____

Pharmacy Information:

In order to expedite prescription service if required we would like to have your pharmacy information on file:

Pharmacy Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Patient's Signature: _____

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Weill Cornell Medical College
Department of Otolaryngology –
Head and Neck Surgery

1305 York Avenue
5th floor
New York, NY 10021

428 East 72nd Street
1st floor, Suite 100
New York, NY 10021

2315 Broadway
3rd floor
New York, NY 10024

156 Williams Street
12th floor
New York, NY 10038

Financial Policy

Welcome to the Department of Otolaryngology-Head & Neck Surgery. The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Also, not all the providers in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the provider you are seeing.

Participating Plans

In this scenario the provider you will see participates with your insurance plan. It is your responsibility to ensure your provider is in fact currently a provider in that plan.

At the time of service you will be responsible for all co-payments as outlined by your plan coverage. The co-payment is typically listed on your insurance card. The Medical College will then submit a claim to your insurance carrier who will pay the College directly and inform you if any deductible or percentage of payment is due from you. You will receive a statement of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, Please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

Non-Participating Plans

In this scenario the providers you will see do not participate in you insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier.

Medicare

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the providers. You will be responsible for any deductible or co-insurance. If your providers do not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

We hope this information is helpful; Again, if you have any questions or concerns, please contact your provider's office.

X_____ _____

Signature of the patient or responsible Party | Date

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NewYork-Presbyterian Hospital
Weill Cornell Medical Center

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March 2014

Dear Patient:

According to Federal guidelines, patients should have their blood pressure checked on a periodic basis by each of their providers.

While we need to comply with these guidelines, please realize that blood pressure management is not in the purview of our practice.

If you feel that your blood pressure today is not consistent with your usual blood pressure, please convey this to your general practitioner or cardiologist.

Sincerely,

The Department of Otolaryngology – Head and Neck Surgery