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

MEDICAL INFORMATION FORM

Your name: _____ Today's date: _____
Date of birth: _____ Age: _____ Weight: _____ Height: _____
Please indicate the name of the referring doctor:_____

1. **Why are you here today?**

2. **Please list your current medications** (including over-the-counter, vitamins, aspirin, herbal medications or birth control):

3. **Please list any allergies to medications, latex or foods:**

4. **Past or current medical conditions** (circle each, Y for yes, N for no):

heart disease	Y / N	high blood pressure	Y / N	high cholesterol	Y / N
asthma	Y / N	allergies	Y / N	acid reflux	Y / N
depression	Y / N	stroke	Y / N	seizures	Y / N
hearing loss	Y / N	HIV	Y / N	thyroid problems	Y / N
diabetes	Y / N	bleeding problems	Y / N	anemia	Y / N
Lyme disease	Y / N	arthritis	Y / N	migraine headache	Y / N

Please list any others:

5. **Please list any surgeries you have had in the past:**

6. **Social history:**

Job description or school grade: _____
Do you smoke? _____ Packs a day? _____ When did you last smoke? _____
How often and how much alcohol do you drink? _____
How much caffeine do you drink in a day? _____
What kind of pets do you have? _____
Are you pregnant? _____ Have you ever fainted when blood was drawn? _____

7. **Please list any medical conditions that run in your family:**

8. **Which pharmacy do you use for prescriptions?**

Reviewed by: _____

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

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

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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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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