Broward ENT Consultants
Ram K. Madasu, MD, FACS

Name:_____
DOB:___/___/____ **age:**_____
Todays date:___/___/____

Child/Minor Patient Medical History

What is the main reason for today's visit?

_____

How long has this been a problem? _____Hours _____Days _____Weeks ____Months ____ Years
Please list any other complaints you want to discuss today

_____

_____

Who is the child's pediatrician or family doctor?_____

Has your child ever taken antibiotics, over the counter meds or other medications for this problem? Yes No
If so, please list._____

Have X-rays, CT scans, MRI scans or allergy tests been obtained for this problem? Yes No
If so, when and where were they taken?_____

Past Medical History

Was your child born full term? Yes No
Any problems with the child's growth and development? Yes No
If yes, please explain _____

Please write down any **previous surgeries** and the approximate dates

_____

_____

_____

Does your child have any **medical problems** that require regular visits to the doctor? (Please check):

__ADD/ADHD
__Anemia
__Asthma/Reactive Airway disease
__Bleeding problems/bruising
__Cancer
__Leukemia/lymphoma
__Ear infections
__Eye problems
__Gastrointestinal problems
__Heart murmur
__Liver/kidney disease
__Diabetes
__Migraine headache
__Muscle/bone problems
__Reflux/heartburn
__Sinus problems
__Skin disease/rash
__Thyroid gland problems

Other:_____

List all medications, including aspirin, other the counter medicines and vitamins, your child takes regularly:

_____

_____

LIST ANY MEDICATIONS OR SUBSTANCES YOUR CHILD IS ALLERGIC TO:_____

_____

Family History **Please list any relatives that have or have had any of the following:**

Hearing loss____ How related _____
Diabetes_____ How related _____
Heart trouble___ How related _____
Bleeding or clotting problems____ How related _____
Cancer _____ How related _____
Asthma_____ How related_____
Allergies____ How related _____

Social History

Who lives at home with the patient? _____

Does anyone at home smoke? Yes No

Are there pets in the home? Yes No

Is the child in school or day care? Yes No

Review of Systems Please circle any problems the child is currently having.

Body as a Whole
Fatigue
Fevers
Weight loss
Weight gain

Head
Headache
Facial pain
Flat spot

Eyes
Mattering
Redness
Dark circles

Ears
Drainage
Decreased hearing
Fluid
Recurrent infection
Pain
Speech delay
Imbalance/not walking
Dizziness

Nose
Drainage
Stuffiness
Bad smell
Polyps
Foreign object
Bleeding
Frequent colds

Allergies
Sneezing
Pets in home
Spring
Summer
Fall
Winter
Foods

Throat
Drainage
Pain
Tonsillitis
Bad breath
Snoring
Large tonsils
Noisy breathing
Throat clearing
Hoarseness
Cough

Neck
Large glands
Pain
Cyst or lump
Thyroid problems

Lungs
Asthma
Wheezing
Bronchitis

Heart
Murmur
Surgery
Extra beats

Stomach
Diarrhea
Constipation
Cramps
Heartburn

Muscle/Bones
Joint pain
Joint swelling
Weakness

Urinary Tract
Frequency
Burning
Stones

Neurological
Seizures
Numbness
Paralysis
Tremor

Psych
Attention deficit
Depression
Anxiety

Skin
Eczema
Itching
Hives
Rash
Moles

BROWARD ENT CONSULTANTS, PL

Ram K. Madasu, M.D.,FACS

Victoria Rojas, Au.D, RN

PATIENT INFORMATION

PATIENT NAME:_____
Last First Middle

SSN:_____ DATE OF BIRTH:_____ SEX: F M

MARITAL STATUS: S M W D

Home Address:_____
Street City ST Zip Code

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Spouse Phone #_____

PRIMARY CARE PHYSICIAN:_____PHONE#_____

PHARMACY NAME:_____PHONE #_____

EMAIL ADDRESS_____

INSURED NAME_____D.O.B_____

INSURANCE NAME_____PPO/HMO

INSURANCE ID #_____

ASSIGNMENT AND RELEASE

I, The undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. Madasu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature_____ Date_____

5511 North University Drive • Suite 101B • Coral Springs, Florida 33067
Tel. 954-755-4002 • Fax 954-755-5010

BROWARD ENT
CONSULTANTS, PL

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

5511 North University Drive, Suite 101 B Coral Springs, FL 33067
Tel (954) 755-4002 Fax (954) 755-5010

Cancellation Policy/No Show Policy/Same Day Cancellation

Cancellation/ No Show Policy for Dr.Madasu Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

I hereby understand that Dr. Madasu; Broward ENT consultations will contact you the day before your appointment and if we do not receive a confirmation back then the appointment will be cancelled.

If you have a Monday morning appointment; we must hear back from you to confirm this appointment by Friday afternoon; your appointment will be cancelled.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If you arrive 15 minutes past your scheduled appointment time we will have to reschedule the appointment.

Account balances

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

_____

Patient Signature Patient/Guardian

____/____/____

Date

Patient Account #_____

(Office Use Only)

AUTHORIZATION TO RELEASE INFORMATION

I HEARBY GIVE MY PERMISSION TO **BROWARD ENT CONSULTANTS** TO RELEASE A COPY OF MY MEDICAL RECORDS (ANY DIAGNOSTIC TESTING/ALLERGY TESTING/PHYCIANS NOTES VISIT NOTES/OP REPORTS OR OTHER LISTED BELOW)

OTHER _____ DATE: _____

PATIENTS SIGNATURE: _____ DATE: _____

ADDRESS: 5511 N. UNIVERSITY DR. SUITE 101B CORAL SPRINGS FL, 33067
PHONE NUMBER: 954-755-4002 FAX NUMBER: 954-755-5010

I HEARBY RELEASE THE FACITILY FROM ANY LIABILITY WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED

PAITENTS NAME PRINTED: _____ DATE: _____

PATIENTS NAME SIGNED: _____ DATE: _____

THE INDIVDIUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUALS INFORMATION, OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITILES TO RECEIVE A COPY OF THIS AUTHORIZATION FORM UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHORIZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL.

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFIYING THE PROVIDING ORGANIZATION IN WRITING, BUT IF I DO, IT WON'T HAVE ANY AFFECT ON ANY ACTIONS THEY TOOK BEFORE THEY RECEIVED THE REVOCATION

I HEARBY AUTHORIZE THE RELEASE OF MY RECORDS AND AUTHORIZATION TO DISCLOSE INFORMATION TO THE FOLLOWING:

NAME _____ SIGNATURE _____

CONTACT _____ RELATIONSHIP: _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY:

PAITENTS NAME: _____ DATE OF BIRTH: _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
YOU MAY NOT USE THIS FORM TO RELEASE INFORMATION FOR TREATMENT OR PAYMENT EXCEPT WHEN THE INFORMATION TO BE RELEASED IS PSYCHOTHERAPY NOTES OR CERTAIN RESEARCH INFORMATION.