PLEASE COMPLETE BOTH SIDES OF THIS FORM

Children's Hospital Boston
The Hospital for Children

Medical Record #
Patient Name
Date of Birth:
Date of Service:

Pediatric Review of Systems

Welcome to the Department of Otolaryngology and Communication Enhancement.

Please take a few minutes to tell us about your child's medical history.

If you need more paper to write additional detailed information, please see a front desk agent.

If you have recently filled out this form and none of the child's history has changed since your last visit, please check this box ☐ and sign the back of this form.

1. ***Why is your child seeing the doctor today?***

2. ***Has your child had any surgery? Circle one: Yes No***

   If yes, type of surgery:

   date of surgery:

3. ***Is there any history of problems with Anesthesia for your child or your family?***

4. ***What medicine is your child allergic to? If none, check here: ☐***

5. ***What medicine is your child currently taking? (Please fill in the chart below)***

Drug name & description/ Strength ***Example:*** ***Drug A, Liquid, 100mg/ml***	How much do you give? ***Example:*** ***300 mg (3mL) or Teaspoon***	How is this drug taken? ***Example:*** ***By mouth***	How often do you give? What time of day? ***Example:*** ***2x/day (8am/8pm)***	Why is your child taking this medication? ***Example:*** ***Ear infection***	When was the last dose given? ***Example:*** ***Today at 8am***

Pediatric Review of Systems (continued)

Medical Record #
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6. Does your child have any of the following problems on a chronic long-term basis: (Please circle all that apply to your child)

General	weight change · fatigue · fevers · night sweats · cancer · pain · failure to gain weight· failure to thrive - short stature	None
Sleep	snoring · stop breathing · daytime sleepiness · frequent awakenings · trouble staying asleep · nightmares · movement during sleep – tosses & turns	None
Immune	frequent infections · swollen glands · runny nose · allergic reactions	None
Allergies	latex · lidocaine · aspirin · sulfa · penicillin · vaccines · bee stings · eggs · hay fever · seafood · peanuts · milk · anti-seizure medicines· other	None
Eyes	blindness · light sensitivity - drooping eyelids - tearing	None
Skin	rash · itching	None
ENT	hearing loss · ringing in ears · sinus problems · sore throat · changes in voice trouble swallowing · tonsillitis · difficulty - abnormal teeth - ear fluid - ear infections	None
Heart	murmur · irregular heartbeat · rheumatic fever	None
Respiratory	wheezing · cough · asthma · pneumonia · night time cough	None
Digestive	heartburn · ulcers · nausea · vomiting · constipation · diarrhea · appendicitis · choking	None
Bladder	loss of bladder control · frequent urination · painful urination · kidney failure	None
Endocrine	diabetes · thyroid problems · high cholesterol · hormone problems	None
Hematologic	anemia · bruise easily · bleed easily · leukemia	None
Musculoskeletal	muscle weakness · arthritis · fractures · bone disease	None
Neurologic	headaches · migraines · dizziness · convulsion · seizures · epilepsy · head injury · meningitis	None
Psychiatric	behavior changes · depression · anxiety · nervous breakdown · alcoholism · drug addiction · hyperactivity · impulsivity · poor attention span	None

Please comment on any of the above symptoms your child has:

7. ***Is there anything you would like us to know about the religious, spiritual, cultural beliefs, traditions, and practices of your family or extended family? Circle one: Yes No***
If yes, please describe:

8. Is there anything you would like us to know about your child's developmental status, psychological status, social circumstance, nutritional status and educational or learning status that may have an impact on their health care?
Circle one: Yes No
If yes, please describe:

Parent or Legal Guardian Signature **Date**

CHMC Otolaryngologic Foundation, Inc.
300 Longwood Ave., LO-367
Boston, MA 02115
Billing Office: 800-488-3858 (508-947-8131)

Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

As a courtesy, we will file your insurance claim for you if you assign the benefits to one of our physicians; in other words, you agree to have your insurance company pay the physician directly. If your insurance company does not pay the practice within a reasonable length of time, we will look to you for payment. All claims are filed within standard HIPAA guidelines.

Your insurance policy is a contract between you and your insurance company; The Otolaryngologic Foundation is not involved. If for any reason (including referral disputes) your insurance company does not pay your bill, you shall ultimately be responsible. **The Otolaryngology department offers a 30% discount to uninsured domestic (residents of the United States) patients/guarantors. Interest is calculated at 18% annually on all self-pay balances over 30 days. There is a minimum monthly charge of $1.50.**
The department offers an additional 10% discount (40% total discount) to uninsured domestic patients/guarantors who pay the entire amount of their estimated bill on or before the date of service.

All Referrals (when required by your insurance contract) must be in place prior to the patient's appointment. A patient who does not have their insurance referral and wishes to be seen outside of their plan, may pay in full (40% discount included) for their visit at the time of service. The only exceptions are established patients who are sent over from Children's Hospital Primary Care Center (CHPCC); or patients who are currently In-Patient within Children's Hospital. All other patients with non-urgent medical issues must reschedule their visit and coordinate a valid referral for that appointment. Your signature below indicates that if services have not been authorized by your insurance company, you shall ultimately be responsible for payment of all charges associated with your visit.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

*****Please note that if you or your child receives Audiology services, this is a separate service, billed by Children's Hospital and not the CHMC Otolaryngologic Foundation. There may be an additional co-pay or deductible due for these services, as well as a separate referral.*****

In order to provide the best possible service and availability to our patients; please call our scheduling line at (617-355-6554) as early as possible if you know you will need to reschedule or cancel your appointment.

Patient Privacy Policy:

CHMC Otolaryngologic Foundation complies with all standard HIPAA rules and regulations. "The Notice of Privacy Practices" is available upon request and is also viewable via the internet by logging on to www.childrenshospital.org. If you require a private registration area when checking in, please alert an agent at the front desk.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. In addition, I have received the HIPAA "Notice of Privacy Practices" policy.

_____ _____
Signature of Patient or Responsible Party if a Minor **Date**

_____ _____
Please Print Name of the Patient **Date**