Pediatric ent

MEDNAX
HEALTH SOLUTIONS PARTNER

Pediatric Ear, Nose and Throat Institute of South Texas
Board Certified Otolaryngology-Head & Neck Surgery
Fellowship in Pediatric Otolaryngology- Head & Neck Surgery

Please complete the following forms to help expedite your visit!

Preferred pharmacy location: _____

Patient Medical History Form

Patient's Name: DOB:

Referring Doctor:

What are your concerns for today's visit?

Past Medical history:

Past illness:

1)

2)

3)

Medications:

1) 3)

2) 4)

16723 Huebner Road
San Antonio, Texas 78248

Telephone: (210) PEDIENT
Fax: (210) 614-5451

Allergies to medications:
Medication: _____
Side effect: _____

Past surgeries:

_____

_____

Please check the "Yes" or "No" box to indicate if your child has had the following illness:

Ear Infection: O Yes O No
If yes, please answer the questions below:
How many ear infections in the past 12 months?
Was there any drainage with the ear infection? O Yes O No
Are both ears draining or just one? O Both O Just one
Are there fevers associated with the ear infections? O Yes O No
Have there been other hearing problems with the infections? O Yes O No
Which antibiotic has your child taken for ear infections in the past 12 months?

_____

_____

Nose or Sinus issues: O Yes O No
If yes, please describe the sinus issues:

_____

_____

Throat infection: O Yes O No
If yes, please answer the questions below:
How many throat infections in the past 12 months? _____
How many of these infections were strep positive? _____
Which antibiotic has your child taken for the throat infections? _____

_____

Frequent snoring: O Yes O No
If yes, please answer the questions below:
Is there tossing and turning during sleep? O Yes O No
Does your child have pauses "apnea" during the snoring? O Yes O No
If yes, how long do the pauses last? _____
Does your child turn blue during the snoring? O Yes O No

Allergy Issues: O Yes O No
If yes, please answer the questions below:
Does your child have frequent sneezing, itchy and watery eyes? O Yes O No
If yes, what allergy medications has your child been on in the past 12 months?
_____
_____

Does your child have an allergist? O Yes O No
If yes, Name:_____
Is your child currently on immunotherapy? O Yes O No

Airway Issues (excluding snoring): O Yes O No
If yes, please describe the airway issue:
_____
Is there noise during the airway problem? O Yes O No
Does the noise occur when your child breathes in our out? O Breathes in O Breathes out O Both

Does your child turn blue during the airway problem? O Yes O No

Thank you for taking the time to complete a medical history form.

I have reviewed the above information.

_____ _____
Juan A. Bonilla, M.D. R.Donald Moe, M.D.

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Consent to Treatment

I,_____ am the: ___Parent ___Legal Guardian __Other (please specify)

I authorize the following Person(s) list relationship

_____ _____

_____ _____

_____ _____

To Make Medical/ Surgical decisions (when necessary)

I hereby give consent to:

X Juan A. Bonilla, MD
X Roderick D. Moe, MD
X Grace S. Hughes, MSN, APRN, FNP-BC

To examine and administer any necessary medical care for my child.

_____

Patient name

_____ _____

Signature Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____
2. _____
3. _____
4. _____

___ **Yes** ___**No** The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

__ Home Voice Mail or Answering Machine Home Phone number: _____

__ Cell phone Cell phone number: _____

__ Work Voice Mail Work phone number: _____

__ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

o Parent/legal guardian o Power of Attorney

*Evidence of authority must be provided and on file with the practice.