MICHAEL A. ROTHSCHILD, M.D.
NEW PATIENT REGISTRATION
T: 212-996-2995   F: 212-996-2703
www.KidsENT.com

Today's Date_____/_____/_____

PATIENT INFORMATION

Name of Patient (Last, First MI)________________________________

Gender: ❑ Male ❑ Female   Date of Birth ________________

Siblings In Our Practice:________________________________

Address________________________________Apt#__________

City________________________State__________ Zip__________

Patient Lives With?________________________Relation to Patient__________

Parent Name________________________ Parent Name________________________

Home Phone________________________ Home Phone________________________

Work Phone________________________ Work Phone________________________

Mobile Phone________________________ Mobile Phone________________________

Email (Optional)________________________ Email (Optional)________________________

Relation to Patient________________________ Relation to Patient________________________

Emergency Contact (not in same household)________________________Phone__________

BILLING: Please complete for policyholder or person responsible for bills.

Name________________________Relation to Patient__________Date of Birth__________

Address________________________________

City________________________State__________Zip__________

Home Phone________________________ Work Phone________________________

Occupation________________________ Employer________________________

Employer Address________________________ City__________ State__________ Zip__________

INSURANCE INFORMATION: Please note that if your carrier requires Pre Authorization or Pre Approval, you are required to obtain them prior to your appointment. You may need to check with your carrier if you have a waiting period for specialists.

Primary Ins ________________________ ID#________________________

Ins Co. Address________________________ Phone________________________

Subscriber/Policy Holder________________________ Relation to Patient________________________

Secondary Ins ________________________ ID#________________________

Ins Co. Address________________________ Phone________________________

Subscriber/Policy Holder________________________ Relation to Patient________________________

MEDICAL CONTACT INFORMATION: A written report will be sent to your primary care physician (PCP) unless otherwise instructed.

Pediatrician/PCP________________________ Pharmacy________________________

Phone________________________ Phone________________________

Address________________________ Address________________________

________________________ ________________________

Other Referral Source________________________________

MICHAEL A. ROTHSCHILD, M.D.
Acknowledgement of Financial & Privacy Practice Policies

Dear Patients:

Welcome to our office! Our goal is to provide the highest standard of patient care and it is essential that we establish a clear understanding of our Financial and Privacy Policy with our patients. Should you have questions or concerns about our fees, policy, your financial responsibility or our privacy practices, please do not hesitate to ask.

IN-NETWORK INSURANCE - Dr. Rothschild participates in various insurance plans. If Dr. Rothschild is considered "in-network" with your carrier, you are responsible for all co-payments at the time of service. You may also have in-network deductibles and coinsurances and will be billed accordingly.

***UNITED HEALTH CARE PATIENTS: Please speak with our office directly if your insurance carrier is United Health Care Mount Sinai.

OUT-OF-NETWORK INSURANCE - We ask for payment in full at the time of service and as a courtesy, we will gladly submit the claim form to your insurance carrier for your reimbursement consideration. Dr. Rothschild's team is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier. Please contact your insurance company directly for details regarding your out-of-net work coverage.

SELF PAY PATIENTS - We ask for payment in full at the time of service and will provide you with a receipt for your records.

MEDICAID - Dr. Rothschild does not accept Medicaid in his private office and you will be responsible for payment at time of service.

REFERRALS - If your insurance company requires a referral to see a specialist, it is the patient's responsibility to obtain prior to the appointment. Please remember that referrals expire and you are responsible for renewing with your primary care physician or pediatrician. If you are unable to obtain a referral prior to your appointment you may be billed for the visit in full.

CANCELLATION POLICY - We understand that unexpected events occur and we ask that you contact the office as soon as possible to cancel or reschedule your appointment. In the event you do not arrive for your appointment you may be charged a cancellation fee.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Dr. Jacqueline Jones or her staff will not be involved with separation or divorce disputes regarding payment and/or services.

PAYMENT METHODS - We accept Visa, MasterCard, American Express, checks and cash.

AGREEMENT

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Michael Rothschild or my insurance company to release any information required to process my claims.

I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Responsible Party Signature____Date____________________

Print Name____ Relationship___________________

Patient Name:____Date of Birth:__________________

How would you like your appointments to be confirmed (Check all that apply):

☐ Home ☐ Cell ☐ Email ☐ Text ☐ Other:__________________

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Today's Date:________________________

Patient Name: ____Patient Date of Birth:____________________

Age:____________________ Gender: ❑ Male ❑ Female Height:____________________ Weight:____________________

Reason for Consultation:

❑ Ear Infection
❑ Ear Aches
❑ Ear Discharge
❑ Ringing in Ears
❑ Hearing Loss
❑ Earwax Build-Up
❑ Sinusitis
❑ Snoring
❑ Sinus Problems
❑ Nasal Obstruction
❑ Nose Bleeds
❑ Nose Fracture
❑ Foreign Body in Ear/Nose
❑ Sore Throat
❑ Swallowing Difficulty
❑ Mouth/Tongue Sores
❑ Thyroid Nodule
❑ Neck Mass
❑ Headache
❑ Vertigo/Dizziness
❑ Allergies
❑ Asthma/Wheezing
❑ Hoarseness
❑ Other ____________________
❑ Speech
❑ Sleep Issues
❑ Second Opinion

Chief Complaint:____

Duration of problem:____ Date symptoms began:____________________

Intensity of symptoms: ❑ Not Applicable ❑ Mild ❑ Moderate ❑ Severe ❑ Excruciating

What relieves symptoms?____

What makes symptoms worse? ____

Is there a time of day or year that makes the symptoms worse?____

Current Medical Conditions:

Yes	No		Yes	No		Yes	No	
❑	❑	ENT Problem other then above	❑	❑	Skin Disease/Rash	❑	❑	Heart Problem
❑	❑	Unexplained Weight Loss	❑	❑	Endocrine/Diabetes	❑	❑	Muscle/Bone Disorder
❑	❑	Unexplained Tiredness	❑	❑	Blood Disease/Disorder	❑	❑	Neurological Disorder
❑	❑	Stomach/Bowel Symptoms	❑	❑	Eye Problems/Disorders	❑	❑	Allergy/Immune Disorder
❑	❑	Breathing Disorder/Problems	❑	❑	Emotional/Behavioral Disorder	❑	❑	Urinary/Kidney Disorder
❑	❑	Other Problem(s):____________________						

MEDICATIONS: List ALL medications you are currently taking including herbs, supplements and over the counter medications.

Drug Name (Generic/brand)	Dosage	Frequency

PAST MEDICAL HISTORY: Please provide a list of all illness, injuries and surgeries.

Injuries & Operations	Date	Treatment	Result

ALLERGIES: Please list all food, medication and other allergies and all reactions.

Allergy To	Reaction

Other health concerns:____

____

Physician Review
Signature:____Date:____________________