Leonard V. Covello, M.D.
Facial Plastic and Reconstructive Surgery
Otolaryngology – Head and Neck Surgery

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900 Ridge Road, Suite E
Munster, IN 46321

(219) 836-8100
Fax (219) 836-9656

RE: Ear, Nose, Throat Exam and/or
Facial Plastic & Reconstruction Exam

To Our New Patient:

Thank you for scheduling an appointment with Dr. Covello. An appointment has been scheduled for you on ____________________ at ______________ A.M. / P.M.

Enclosed are three forms that will need to be completed and brought with you to this appointment. Along with these forms, please bring your insurance cards, and a license with current address/photo I.D. Also, please bring any CT films, MRI reports, hearing tests or other reports that would help in your diagnosis. **Copayments and deductibles are due at the time of your appointment.** Our office accepts cash, check or credit cards (Master Card, Visa and Discover).

As of October 3, 2006, we no longer accept Medicaid as a primary, secondary, or tertiary insurance. We are notifying you of this to make you aware that you will be responsible for any balances that would have been covered by Medicaid.

If you should have any questions, please contact our office at (219) 836-8100.

Sincerely,

Beth Roche
Office Manager

PEDIATRIC PATIENT INFORMATION (<18 Yrs)

and Authorization to Treat Minor

Name: ______________________________ ____________________ __________
(Last) (First) (Middle Initial)

Address: ____

City: _________________________ State: ___________ Zip Code: _____________

Social Security #: _____ - _____ - ________ Date of Birth: ____ - ____ - __________

Home Phone: ( ) __________________ Cell Phone: ( ) __________________

Guardian's Name: _________________________ Date of Birth: ____ - ____ - __________

Guardian's Employer: _________________________ SSN #: _____ - _____ - _________

Employer's Address: _________________________ Work #: ( ) _________________

Insured's Name: ___________________________ Date of Birth: ____ - ____ - _________

Insured's Employer: ________________________ SSN #: ______ - ______ - _________

Emergency contact not living with you: __________________ Phone #:( ) ____________

Referral Source (physician/individual that referred you): ______________________________

Pharmacy Name: ______________________________ Phone #: ( ) ______________

Pharmacy Address: ____

List allergies to medications: ____

As the parent/guardian of the above named child/minor, I hereby give permission to Leonard V. Covello, M.D. to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my child's/minor's account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____________________________________ _________________________
Signature of Parent or Guardian Date

Relationship to child/minor, if not parent _________________________

MEDICAL HISTORY (Pediatric: <18 yrs)

Please describe the reason for your visit: ______________________________

____

Please list all drug related allergies or intolerances: ______________________________

Please list all medications your child is currently taking (including over-the-counter medicines, aspirin, birth control pills, vitamins) along with the dosage: ______________________________

____

Were there any known health problems, maternal or fetal, during pregnancy? YES NO

If yes, please specify. ______________________________

Did your child require any special care as a newborn (including but not limited to)?:

- ☐ Special Care Nursery
- ☐ Intensive Care
- ☐ Hospitalization for infection
- ☐ High bilirubin with ultraviolet treatments
- ☐ Low Birth Weight (less than 4 lbs)
- ☐ Other ______________________________

Have there been any problems with your child's development? (growth, motor skills, speech, hearing, language)

____

If your child has been hospitalized for any reason, please describe. ______________________________

____

Does your child have a history of (check all that apply)?:

- ☐ Ear Infections
- ☐ Chronic or Night Cough
- ☐ Bedwetting
- ☐ Meningitis
- ☐ Mouth Breathing
- ☐ Frequent Crying
- ☐ Heart Problems
- ☐ Snoring
- ☐ Head Trauma
- ☐ Lung Problems
- ☐ Irritability
- ☐ Prolonged High Fevers
- ☐ Kidney Problems
- ☐ Asthma
- ☐ Positive HIV/AIDS
- ☐ Diabetes
- ☐ Other ______________________________

Any other major illness not listed above: ______________________________

Is there a family history of (check all that apply)?:

- ☐ Bleeding Tendencies
- ☐ Anesthetic Reactions
- ☐ Allergies
- ☐ Hearing Loss
- ☐ Diabetes
- ☐ Congenital Defects

Did your child pass his/her newborn hearing screening? YES NO

If no, was he/she retested after hospital discharge? YES NO Results: ______________________________

Who is your child's pediatrician? ______________________________

Do we have permission to contact the pediatrician? YES NO Phone # ______________________________

By signing below, I agree that the above information above is complete and correct to the best of my knowledge.

______________________________ Print Child's Name

______________________________ Child's Date of Birth

______________________________ Parent or Guardian Signature

______________________________ Today's Date

Patient's Name: ____________________________________

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Leonard V. Covello, M.D. 900 Ridge Road Suite E, Munster, IN 46321

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy and payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize office staff to make reminder calls and leave medical messages as needed.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the physician to initiate a compliant to the insurance commissioner for any reason on my behalf.

I understand that Dr. Covello's office reserves the right to charge interest or a said fee on delinquent accounts. Also, a late fee of $25.00 may be placed on budget accounts that are not paid on a monthly basis.

I further understand that it is my responsibility to give 24 hours notice of a cancelled appointment. A fee of $45.00 will be charged for failure to give notice of cancellation of an appointment.

Date ______________________________

Signature of policy holder ____

Signature of claimant, if other than policy holder _____________________________________