

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Sex: F • M

Address _____ City _____ State _____ Zip _____

Name & Phone number of Primary Care (Family) Physician/Pediatrician _____

Referring Physician Name & Address (if different) _____

Marital Status: Single • Married • Divorced • Widowed • Separated

Student Status: PT • FT

Home Phone _____ Day Phone _____ Cell Phone _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ Retired? Y • N

Name of Spouse/Parent/Legal Guardian _____ DOB _____

Primary Medical Insurance (Responsible Party)

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Policy Holder's Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Co-pay Amount _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Policy Holder's Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Co-pay Amount _____

Emergency Contact: _____ Phone #: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I have reviewed Specialists in ENT notice of privacy practice.

Responsible Party Signature: _____ Date: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of \$20 may be added to your account.
- **INSURANCE PLANS**- You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, payment will be due at the time services are rendered. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Specialist in ENT for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.
Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Specialists in ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits
- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** - The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Specialists in ENT will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for fifty dollars(\$50.00) or 20% of the balance owed, whichever is greater.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA OR AMERICAN EXPRESS .

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

FAMILY HISTORY: Circle YES if anyone in your family has had the following:

ADD/ADHD	Yes	Hearing deficiency	Yes
Alcoholism	Yes	Hyperlipidemia	Yes
Allergies	Yes	Hypertension	Yes
Alzheimer's Disease	Yes	Irritable Bowel Syndrome	Yes
Asthma	Yes	Migraines	Yes
CAD (Coronary Artery Disease)	Yes	Nerve Hearing Loss	Yes
Cancer Type: _____	Yes	Obesity	Yes
CVA (Stroke)	Yes	Osteoarthritis	Yes
Depression	Yes	Osteoporosis	Yes
Developmental delay	Yes	PVD (Peripheral Vascular Disease)	Yes
Diabetes	Yes	Renal disease	Yes
Eczema	Yes	Seizure disorder	Yes
		Other: _____	

Tobacco Use? Yes • No • Former

Do you consume alcohol? Yes • No • Former

	Packs/Day	For? Years	Yr. Quit?		Type of Alcohol	Frequency?	Amount?	Last Drink?
Cigarettes								
Other:(list type)								

Exposed to second hand smoke? Yes • No

Caffeine Consumption? Yes • No Type: _____ Amount per day? _____

REVIEW OF SYSTEMS: Circle any of the following problems you have recently had:

General health problems:

fatigue • fever • night sweats • unintentional weight loss • sleeping problems • weight gain

Eye problems:

double vision • itchy eyes • swelling • redness

Ear problems:

ear drainage • hearing loss • ear infections • dizziness • itchy • noise exposure • ringing /noise in ears • ear pain

Nose & Sinus problems:

chronic congestion • mouth breathing • nosebleeds • frequent sneezing • runny nose • post-nasal drip

Mouth & Throat problems:

difficulty swallowing • snoring • sore throat • hoarseness • sores in mouth • ulcers

Heart or circulation problems:

heart murmur • leg cramping • swelling of ankles • chest pain • blacking out • irregular heartbeat

Lung or respiratory problems:

shortness of breath • wheezing • cough

Stomach problems:

abdominal pain • diarrhea • heartburn • nausea • vomiting

Brain or Nervous system problems:

headache • seizures • weakness • numbness • facial pain

Glands & Hormone problems:

intolerance to heat • increased appetite • neck enlargement • intolerance to cold

Blood or Lymph nodes problems:

bleeds excessively after injury • bruises easily

Allergy problems:

food intolerances • insect bites

Skin:

rash • itchy • latex allergy • swelling • urticaria / hives

What is the reason you are here today? _____

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

PATIENTS NAME: _____ BIRTHDATE _____

Please fill out the following information and sign.

Specialist in Ear, Nose and Throat **MAY** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers we may contact you or leave messages at.

Home: _____

Work: _____

Cell: _____

If patient is a minor, parent or guardians name: _____

Lists of persons or family members whom we may leave private health information with.

_____ relationship _____

_____ relationship _____

I have been provided an opportunity to review the Notice of Privacy Practices and understand the contents of this form.

Name: _____

Signature: _____

Date: _____