PATIENT INFORMATION TODAY'S DATE_______________

Name____

Address___________________________ City___________________________ ST______ ZIP______________________

Home Phone (_____)____________Cell Phone (_____)____________ Work Phone (____)________________________

SS#______-______-______ Date of Birth____/____/____ Age______ Sex M F

PATIENT'S RESPONISBLE PARTY (IF DIFFERENT FROM ABOVE)

NAME____

ADDRESS___________________________ CITY___________________________ ST______ ZIP__________________

Home Phone (_____) ____________Cell Phone (_____) ____________ Work Phone (____)______________________

SS#______-______-______ Date of Birth____/____/____ Age______ Sex M F

INSURANCE INFORMATION *PLEASE PRESENT CARD AT TIME OF CHECK IN*

Primary Insurance Name____________________

Name of Insured___________________________

Insured's ID #______________________________

Group #____________________________________

Relationship of patient to insured_____________

Secondary Insurance Name_____________________________

Name of Insured____

Insured's ID #____

Group #____

Relationship of patient to insured___________________________

PHARMACY OF CHOICE:____

CITY:_____________________________PHONE: (_____)________________FAX: (____)________________________

PRIMARY CARE PHYSICIAN:______________________________PHONE:(____)_________________________

MEDICARE PATIENTS: I request that payment for authorized Medicare benefits be made either to me or on my behalf to Laurel ENT & Allergy, PC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Name: ____ Date: ___________________________

I authorize the release of medical information to my PCP or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications & prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party__________________________________ Date: ___________________________

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding or payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Applicable copayments and deductibles will be collected. We accept payment in form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate Insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. If payment is not made to our office in full within 30 days you may incur a late fee. If further collection is required you could incur collection fees, attorney fees, and all court costs to collect upon any debt you have owing our office.

Patient or Responsible Party:___________________________________ Date:__________________________

Patient History Form Complete ***BEFORE*** First Visit

Patient Name____ Date____/____/____

How did you hear about us?

___Internet ___Advertisement ___Friend/Family

___PCP Referral (Dr.'s Name)____

___Specialist/Doctor other than PCP (Dr.'s Name)____

What is the main reason for your visit today? Please describe in detail____

____

____

List any previous surgeries you've had; include all previous ENT procedures______________________________________

____

What medications are you allergic to, what type of reaction to the medication do you have?________________________

List all medications you are presently taking, including nasal sprays____

____

____

Have you had any recent imaging of your head or sinus in the past 2 years? CT Sinus MRI Xray When? ________

Are you or have you ever been on allergy immunotherapy? YES/NO/WAS. If yes, how long have you been on shots and how often do you get them?____

If you were, when and why did you stop?____

Do you or have you ever smoked? YES NO If so, how much & how long______________________________

FORMER smoker, roughly when did you quit?_______________

Do you drink caffeinated beverages? YES NO If so, how much? ____

Do you have difficulty breathing through your nose? YES NO

Do you Snore? YES NO

Do you get drainage from your nose frequently? YES NO Is it /or does it become discolored? YES NO

Do you have facial pain/headaches? YES NO If yes, rate it on a scale of 1-10 (10 being highest) _______

Do you feel pain in cheeks? YES NO Forehead? YES NO Between your eyes? YES NO

If yes, do you have headaches approximately how many days per month?

Never ____ 0-1 _____ 2-5 ______ 6-15______ Greater than 15 _______

Is your sense of smell diminished? YES NO Do you have a family history of Nasal Polyps? YES NO

How many times have you been on antibiotics for a sinus infection in the past 6 months? NONE 1 2-4 5 or more

How many times have you been on steroids in the past 6 months? NONE 1 more than 2

Do you use nasal steroid sprays? YES NO If yes, how long have you been on them? _________

PAST MEDICAL HISTORY:

_______ Abnormal Bleeding
_______Asthma
_______Cancer, What type?
____
_______Difficulty Swallowing
_______ Thyroid Disease

________ Goiter
________Heart Ailments
________High Blood Pressure
________Heartburn/Gastric Reflux
________Frequent Sore Throat
________ Sleep Apnea

_______ Tonsilitis
_______Nose Bleeds
_______Ear Infections
_______Hoarseness
_______Frequent Cough

FAMILY HISTORY:

Please list any **BLOOD RELATIONS** who have had the below diseases:

Cancer, what type? ____

Thyroid Disease? ____

Allergies? ____

Sinus Problems?____

Asthma?____

Laurel ENT and Allergy, PC

AUTHORIZTION TO RELEASE INFORMATION

This office adheres to strict policies with regard to release of confidential information. If you authorize Laurel ENT and Allergy, PC staff to release information regarding your care to family members, please list their full names, phone number and relationship to you.

NAME:_____________________________**PHONE:**_____________________**RELATIONSHIP:**______________

NAME:_____________________________**PHONE:**_____________________**RELATIONSHIP:**______________

NAME:_____________________________**PHONE:**_____________________**RELATIONSHIP:**______________

EMERGENCY CONTACT

Please give the name and number of a relative or friend whom we may contact in the event of a medical emergency.

NAME:_____________________________**PHONE:**_____________________**RELATIONSHIP:**______________

NAME:_____________________________**PHONE:**_____________________**RELATIONSHIP:**______________

TELEPHONE MESSAGES

We may need to contact patients regarding appointments, scheduling tests, test results, etc. It may be necessary for us to contact you. It is our policy to leave detailed messages at your home if you are not available or we may need to contact you at work if an emergency arises.

May we contact and/or leave a message at home? YES NO

May we contact and/or leave a message at home? YES NO

____

PATIENT SIGNATURE **DATE**

Laurel ENT and Allergy, PC

Statement of Patient Financial Responsibility

Laurel ENT and Allergy, PC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment of our fees in full. As a courtesy, we will verify coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for your payment of any deductible and copayment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period you will be responsible for your balance in full.

By signing below, I state that I have read and agree to the above policy regarding my financial responsibility to Laurel ENT and Allergy, PC, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Laurel ENT and Allergy, PC, the full and entire amount of bill incurred by me or the above named patient; if applicable any amount due after payment has been made by my insurance carrier is my responsibility.

Patient Signature_____________________________________ Date________________________

Guarantor Signature__________________________________ Date________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize Laurel ENT and Allergy, PC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Laurel ENT and Allergy, PC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature_____________________________ Date______________________

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work of family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand that if I no show for 3 consecutive appointments, or cancel for a total of 3 appointments, I may be discharged from care.

The practice will notify you in writing, via certified mail if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature_____________________________ Date______________________

Failure to Pay

If you fail to remit payment after 90 days you will automatically be sent to collections, any additional fees may be applied and will be your responsibility. It is your responsibility to remit in full, and in the entire amount owed to the collection agency.

Patient/Guarantor Signature____________________________ Date_______________________