

Due to newly enacted FEDERAL MANDATES, we are now required to obtain some additional information from you. Please complete the following items as best possible:

Patient's Name _____ Date of Birth _____

Pharmacy Name and Phone Number _____

Name of Mail Order Pharmacy _____

Reason for visit _____

Specific instructions: the two questions below are designed to identify you ethnicity and race. Regardless of your answer to question 1, go to question 2.

Question 1. Are you Hispanic/Latino (choose only one)

_____ No, not Hispanic/Latino?

_____ Yes, Hispanic/Latino (A person who is Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race).

Question 2. Please select the racial category or categories with which you most closely identify.

_____ American Indian or Alaskan Native _____ Asian _____ Black or African American

_____ Native Hawaiian or Other Pacific Islander _____ Caucasian

Language of choice _____

Tobacco use: Never _____ Currently using _____ Formerly used tobacco _____

Height _____ feet _____ inches Weight _____ lbs

Have you ever received a Pneumovax (pneumonia) vaccine? Yes _____ No _____ Unsure _____

Have you had a flu shot this flu season (since September 1)? Yes _____ No _____ Unsure _____

Have you been tested for COVID/Corona Virus? Yes _____: Positive / Negative Date _____ No _____

Women over 40; have you ever had a mammogram? Yes _____ No _____ Unsure _____

We are required to update your health information at each and every visit. Please bring with you to each visit a current list of all medications (including dosage and frequency) as well as a list of any new medical problems or allergies.

Please list current medications:

Allergies to medication:

Matthew Nagorsky, MD

Raymond Lesser, MD

Seth Zwillenberg, MD

University Otolaryngology Associates, P.C

(Office use only)

Name _____ Date _____
Last, First, Middle Initial –As it appears on your insurance card

PATIENT DATA

Phone Numbers:

Address: _____

_____ [] Home [] Cell [] Work

City : _____ State _____ Zip _____

_____ [] Home [] Cell [] Work

Soc Sec No: _____

_____ [] Home [] Cell [] Work

Birthdate: _____ Marital Status: _____ Sex: Male/Female

Emergency

Email: _____

Contact: _____ Phone _____

Preference for Appointment Reminders [] Home [] Cell ___call ___text [] Work

FAMILY PHYSICIAN

Name: _____ Phone #: (_____) _____

Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Subscriber's Name (If different than patient): _____ Relationship: _____

Sex: Male / Female (Circle one) Birthdate: _____ S.S.# _____

ID/Plan #: _____ Group#: _____

Secondary Insurance Carrier: _____

Subscriber's Name: _____ Relationship: _____

Sex: Male / Female (Circle one) Birthdate: _____ S.S.# _____

ID/Plan #: _____ Group#: _____

Medicare Secondary – please give reason:

Patient/Spouse working (12) Disability (43) Other – please specify: _____

OTHER INSURANCE (Circle one) Motor Vehicle Worker's Comp.

Date of Accident: _____ MV/WC Company: _____

Adjuster' Name: _____ Phone #: (_____) _____

Address: _____

****VERY IMPORTANT**** Claim #: _____ Policy # _____

Policy Holder's Name (if other than patient) _____

Name: _____

DOB: _____

(Office use only)

PATIENT'S PAYMENT RESPONSIBILITY:

I, the guarantor understand that I am fully responsible for all fees payable to University Otolaryngology Associates, P.C., and / or any associate rendering medical treatment to me or the patient for whom I am financially responsible.

LEGAL, MOTOR, VEHICLE, OR WORKERS' COMPENSATION CASES:

I understand that if I am involved in any of these types of cases, I must present all relevant documentation before any service with the physician. I must also present my personal health insurance coverage, for coverage if my accident – related coverage, expires, or terminates. If the appropriate information is not presented at the time of service, all balances will become my responsibility.

CLAIMS SUBMISSIONS:

Depending on my insurance carrier, the doctors' office may file directly to the insurance company for services rendered in the office. Claim submission policies for participating and non-participating insurances are located in the billing office for review. I am aware of the relevant insurance companies with which the doctors participate and I am fully aware it the physician I am to see is a participating or non-participating in the medical insurance plan that I am covered under. By signing this agreement, I acknowledge that I am fully aware of my co-pays, deductibles, and non-covered services. I am also aware that my co-pay is due before I leave the office at each visit. I acknowledge that the doctor's office will bill me for balances due and that I am fully responsible for all balances billed.

REFERRAL:

I understand that it is my responsibility to bring a referral authorization with me at the time of each service date, if my insurance company requires such an authorization. If the referral is not presented prior to services being rendered, I acknowledge that I will sign a financial release form, holding the guarantor personally responsible, for any services that are not covered by my insurance carrier for that visit date.

PAYMENT PLANS AND COLLECTION:

I acknowledge that the doctor's office can submit any unpaid balance due over 121 days to a collection agency. I also acknowledge that if I am unable to pay the entire balance, I may arrange to make monthly payments with the billing office. If I am not consistent with my monthly payments, my full balance may be placed with the doctors' collection agency after one notice.

PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of University Otolaryngology Associates, Inc.'s Notice of Privacy Practices.

Name of Personal Representative, if applicable: _____

CONFIRMATION/MISSED APPOINTMENT POLICY

Our office will contact you to confirm 1-2 days prior to your appointment (please inform us of any changes to your contact information). Please confirm or cancel your appointment 24 hours before; if appointments are not verified we can not guarantee your spot will be held. Patients who do not keep scheduled appointments must pay a fee in order to schedule a future visit.

Initials _____

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL AND FINANCIAL INFORMATION:

The signature below will authorize University Otolaryngology Associates, P.C., and / or any associate of the practice to furnish or receive from physician(s) / attorney(s) / insurance company _____ any information and / or opinions which they require, or to photocopy the same.

I request that payment of authorized Medicare / insurance benefits be made either to me or on my behalf to University Otolaryngology Associates, P.C., for any services furnished to me by the practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature

Date

Guarantor's Signature

Date

MEDICAL INFORMATION FORM

NAME: _____ DOB: _____ # _____

(Office use only)

DATE: _____ REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack
Date: _____ | <input type="checkbox"/> Reflux | <input type="checkbox"/> Cataract | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Heart Surgery
Date: _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Breast |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Stroke
Date: _____ | <input type="checkbox"/> Insulin | <input type="checkbox"/> Bone |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tremor | <input type="checkbox"/> Thyroid Surgery
Date: _____ | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Weakness | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Dialysis
Date Began: _____ | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Psoriasis |
| | | | <input type="checkbox"/> Dermatitis |
| | | | <input type="checkbox"/> Hives |

SOCIAL HISTORY

- Alcohol Beer Tobacco

SURGERY

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Brain | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Stapedectomy | <input type="checkbox"/> Breast | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Joint Scope |
| <input type="checkbox"/> Mastoidectomy | <input type="checkbox"/> Back | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nasal/Sinus | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia | _____ |

SYMPTOMS

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Headache | <input type="checkbox"/> Arm/Leg Pain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Arm/Leg Weakness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Ear Drainage | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Slurred Speech | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Facial Weakness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Ear Pressure | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Cough | <input type="checkbox"/> Sleep Trouble |
| <input type="checkbox"/> Nasal Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Wheeze | |
| <input type="checkbox"/> Nasal Drainage | <input type="checkbox"/> Neck Pain | | |
| <input type="checkbox"/> Sneezing | | | |
| <input type="checkbox"/> Facial Pain | | | |
| <input type="checkbox"/> Sinus Pressure | | | |

DRUG ALLERGIES

- Penicillin (Keflex, Amoxicillin) Erythromycin Sulfa Other _____ No Known Drug Allergies

Other problems or information we should know: _____

