# ENT Family Clinic ~ Sinus and Snoring MD
# Patient Registration Form

SINUS & SNORING MD
ENT FAMILY CLINIC

## Patient Information

| Last Name | MI | First Name | |
|---|---|---|---|
| Gender / Social Security Number | | Date of Birth | Marital Status |
| Address | City | State | Zip |
| Email Address | Cell Phone | Home Phone | |
| Referred By | Primary Care Provider | | |
| Pharmacy Name | Pharmacy Address | | |
| Emergency Contact Name | Relationship to Patient | Phone | |

## Insurance Information

**Primary Insurance**

| Insurance Carrier Name | Group Number | ID Number |
|---|---|---|
| Insured's Name | Insured's Birthdate | Relationship to Insured |

**Secondary Insurance** (If you do not have secondary or a supplement insurance, please write NONE in the box below)

| Insurance Carrier Name | Group Number | ID Number |
|---|---|---|
| Insured's Name | Insured's Birthdate | Relationship to Insured |

## Responsible Party

| Billing Name (if other than patient) | Phone | Relationship to Patient |
|---|---|---|

## DISCLAIMER

**We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowledge of your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains. If your account is more than 90 days past due, it will automatically forward to our collection agencies system. Partial payments will not be accepted unless otherwise negotiated. By signing this statement, I agree to assume responsibility for services not paid by my health insurance, in whole or part. I further authorize the release of any medical information necessary to process my claims**

Signature of Patient or Guardian _____ Date _____

**ENT Family Clinic ~ Sinus and Snoring MD**
**Medical History Questionnaire**

SINUS & SNORING MD
ENT FAMILY CLINIC

Patient Name: _____ Gender: _____ Age: _____ Date: _____

Reason for visit: _____

**Please check all that apply below:**

| | | | |
|---|---|---|---|
| _____ Chest Pain | _____ Nasal Allergies | _____ Asthma | _____ Dizziness |
| _____ Difficulty Breathing | _____ Sinus Infections | _____ Diabetes | _____ Hearing Loss |
| _____ Heart Issues | _____ High Blood Pressure | _____ Postnasal Drip | _____ Stroke |
| _____ Lung Issues | _____ Hepatitis | _____ Nose Bleeds | _____ TIA's |
| _____ Kidney Issues | _____ Ulcer | _____ Stuffy Nose | _____ Heart Murmur |
| _____ Positive HIV/AIDS | _____ Anemia | _____ Headaches | _____ Snoring Sleep Apnea |

| **Please check Below:** | **Yes** | **No** | | **Yes** | **No** |
|---|---|---|---|---|---|
| Recent Cold / Flu | ☐ | ☐ | Acid Reflux / GERD | ☐ | ☐ |
| Chest Pain / Angina | ☐ | ☐ | Stroke / TIA / Seizures | ☐ | ☐ |
| Heart Attack / Irregular Heartbeat | ☐ | ☐ | Paralysis / Muscle Disease | ☐ | ☐ |
| Angioplasty / Stent | ☐ | ☐ | Bleeding Problems / Easy Bruising | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Asthma / COPD / Shortness of Breath | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Sleep Apnea / CPAP / Severe Snoring | ☐ | ☐ | Smoking | ☐ | ☐ |
| Alcohol Use | ☐ | ☐ | Recreational Drugs | ☐ | ☐ |
| Substance Dependency | ☐ | ☐ | Unusual Reaction to Anesthesia | ☐ | ☐ |
| Possibility of Pregnancy | ☐ | ☐ | Exposure to HIV / AIDS | ☐ | ☐ |
| Liver / Kidney Disease | ☐ | ☐ | | | |

Family Medical History: _____

Please list all operation and hospitalizations you have ever had, along with approximate dates:

_____

_____

Major Illness not listed above: _____

Primary Care Physician: _____ Phone Number: _____

List Current Medications (prescription and nonprescription) and supplements: None ☐

| | | |
|---|---|---|
| 1. | 2. | 3. |
| 4. | 5. | 6. |
| 7. | 8. | 9. |

List all Known Allergies: None ☐

| | | |
|---|---|---|
| 1. | 2. | 3. |
| 4. | 5. | 6. |

I agree that all the information above is complete and correct.

Patient or Guardian Signature: _____ Date: _____

**ENT Family Clinic ~ Sinus and Snoring MD**
**HIPAA Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information. The notice contains a patient's rights section describing your rights under law. You establish that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to your use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be reactive.

**By signing this form, I understand that:**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

**I acknowledge that I was provided with the Notice of Privacy Practices for Ear, Nose and Throat Family Clinic**

Print Name of Patient: _____

Signature of Patient or Guardian: _____ Date: _____

**Please answer the following questions below by circling your response:**

May we contact you by phone, email, or text to confirm appointment? Yes No

May we leave a message on your answering machine at home or cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

**ENT Family Clinic may discuss my condition with the following people:**

| | **Name** | **Relationship** |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

## ENT Family Clinic ~ Sinus and Snoring MD
## Authorizations and Disclosures

SINUS & SNORING MD
ENT FAMILY CLINIC

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

**Authorization to Release Medical Information:** For purpose of reimbursement, FMLA, life insurance, and disability, Sinus and Snoring MD and each attending or treating practitioner, including, but not limited to pathology, surgical facility, anesthesia, radiology, and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other third-party payors, or agencies as may be necessary to verify or process all claims for coverage, third party reimbursement or any formal correspondence. Unless specifically instructed otherwise, Sinus and Snoring MD and each attending or treating practitioners are hereby authorized and directed, during this period of admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment under 431.061-065, RSMO (1979). Each of the undersigned does hereby release and hold Sinus and Snoring MD, its officers, directors, agents, employees, and all examining and treatment practitioners harmless of and from all costs, lost damage, or liability resulting from or arising out of such disclosures.

**Notice of Financial Responsibility:** I understand that I am financially responsible to Sinus and Snoring MD for all charges associated with the services rendered by Sinus and Snoring MD, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Sinus and Snoring MD verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all the charges, Sinus and Snoring MD will pursue the internal appeals provided by the health plan and will bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Sinus and Snoring MD may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.

2. Fees for anesthesia, pathology, and laboratory services are not included in the global billing of Sinus and Snoring MD and are billed separately where applicable.

3. When a payment is received by the patient, directly from the health plan they have Sinus and Snoring MD, the patient must endorse and forward the payment and Explanation of Benefits to Sinus and snoring MD as soon as the payment is received to avoid additional financial liability.

Print Name of Patient_____

Signature of Patient or Guardian:_____ Date:_____


Office (262) 652-2887
Fax (262) 764-0224
sinusandsnoringmd.com

6127 Green Bay Rd.
Suite 100
Kenosha, WI 53142

8870 S. Mayhew Dr.
Suite 300
Oak Creek, WI 53154

250 W. Kensington Rd.
Suites 3B & 1A
Mount Prospect, IL 60056