

ENT Family Clinic ~ Sinus and Snoring MD
Patient Registration Form



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
Primary Care Physician Name		Primary Care Physician Phone Number/Address/Town		
Other Physician Referred By Name, if applicable		Other Physician Phone Number/Address/Town		
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
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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

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

Reason for visit: _____

Occupation: _____ Language Preferred: _____

Medical History- Please check all that apply below:

____ Seizures	____ Sinus Infections	____ Heart Attack/Irregular Heartbeat
____ Stroke/TIA	____ Stuffy Nose	____ Kidney Issues/Disease
____ Acid Reflux/GERD/Ulcer	____ Sleep Apnea	____ Liver Disease/Hepatitis
____ Dizziness/Vertigo	____ Asthma	____ Diabetes
____ Headaches/Migraines	____ Difficulty Breathing	____ Thyroid Disease
____ Hearing Loss/Tinnitus	____ COPD	____ Anemia
____ Nose Bleeds	____ Shortness of Breath	____ Bleeding Problems/Easy Bruising
____ Postnasal Drip	____ High Blood Pressure	____ Positive HIV Aids
____ Snoring	____ Heart Murmur	____ Paralysis/Muscle Disease

Other medical conditions not listed above: _____

Social History:

Do you use tobacco? _____ If yes, how much per day: _____ How many years: _____

Do you, or have you used recreational drugs? _____ yes _____ no

Do you drink alcohol? _____ If yes, how much in a week? _____

Surgical History: Please list all operations and hospitalizations you have ever had, along with approximate dates:

Are you on blood thinners? _____ Yes _____ No

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
Questionnaire



Name: _____ Date: _____ DOB: _____

Please place a checkmark in the column to the right of the symptom if you are experiencing these issues.

1. Need to blow nose	[]
2. Sneezing	[]
3. Runny nose	[]
4. Nasal obstruction	[]
5. Loss of smell or taste	[]
6. Cough	[]
7. Post-nasal discharge	[]
8. Thick nasal discharge	[]
9. Ear fullness	[]
10. Ear pain	[]
11. Facial or sinus pain/pressure	[]
12. Difficulty falling asleep	[]
13. Waking up at night	[]
14. Lack of a good night's sleep	[]
15. Waking up tired	[]
16. Fatigue	[]
17. Ear pressure	[]
18. Ear popping	[]
19. Ear fluid	[]
20. Clogged ear	[]
21. Ear pain while flying	[]
22. Sinus pain while flying	[]
23. Ear pain with the change of weather	[]
24. Sinus pain with change of weather	[]
25. Frequent sinus infections	[]
26. Nasal congestion	[]
27. Nasal allergies	[]
28. Mouth dryness in the morning	[]
29. Mouth breathing at night	[]
30. Throat clearing	[]

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:

<u>Name</u>	<u>Relationship</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

ENT Family Clinic ~ Sinus and Snoring MD
Authorizations and Disclosures



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 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



Media Release Consent Form

I consent that Ear, Nose and Throat Family Clinic of Wisconsin, S.C. (DBA Sinus and Snoring MD/Dr. Nariz) may use my image (photographs or videos) for use in education, publications on their website, or other electronic forms of media and social media. Pictures will be de-identified medical images so that my name and identity will not be revealed.

Name (please print): _____

Signature: _____

Date: _____