EAR NOSE & THROAT CENTER OF NEW JERSEY, PA

Name:_____ Date of birth:_____ Age:_____
Sex: M____ F____ Check appropriate: Minor:___ Single:___ Married:___ Divorced:___ Widowed:___
SS#:_____-_____-_____

Home Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____
Best number to contact you: _____-_____-_____
Emergency Contact Name and Number:_____ Relationship:_____
E-mail Address (For Appointment Reminders):_____@_____.com

Employer Name:_____ Work Phone:_____-_____-_____
Address:_____ City:_____ State:_____ Zip:_____

Primary Doctor:_____ Doctor's Address/Telephone:_____
Whom may we thank for referring you?_____

RESPONSIBLE PARTY

Name of person responsible for this account:_____ Relationship:_____
Date of birth: _____ SS#:_____-_____-_____ Home Phone:_____-_____-_____
Home Address:_____ City:_____ State:_____ Zip:_____
Employer Name:_____ Employer Address:_____
Work Phone:_____-_____-_____
Is this person currently a patient at our office? Yes_____ No_____

PRIMARY INSURANCE

Insurance Name:_____ ID#:_____ Group#:_____
Insured's Name:_____ Date of birth:_____ SS#:_____-_____-_____
Employer's Name:_____

SECONDARY INSURANCE

Insurance Name:_____ ID#:_____ Group#:_____
Insured's Name:_____ Date of birth:_____ SS#:_____-_____-_____
Employer's Name:_____

INSURANCE AUTHORIZATION FOR ASSIGMENT OF BENEFITS/INFORAMTION:

I, the undersigned, authorize payment of medical benefits to Ear Nose & Throat of New Jersey, PA for services furnished by the physician. I also understand that I am financially responsible for any amount not covered by contract. I also authorize you to release to my insurance company or their agent information concerning healthcare advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating the patient and administering claims of benefits.

_____ _____

Patient, Parent of Guardian Signature (if child is under 18 years old) Date

PATIENT PAYMENT POLICY

Thank you for choosing our practice! We are committed to the success of you medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly ask financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

Do I need a Referral?

If you have an HMO plan in which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, please call your primary care physician to obtain it. If you are unable to obtain a referral at that time, you will be rescheduled, or you will be required to pay for the full office visit. Once we receive the referral we will reimburse you.

What if my child needs to see a physician?

A parent or legal guardian must accompany minors to all patient visits. This accompanying adult is responsible for payment of the account, according to your policy.

How may I pay?

We accept payments by cash, checks (for established patients), Visa, MasterCard. If your check happens to be returned to us for insufficient funds, you will be responsible for any bank fees that are charged to our practice.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility. I also understand I will be seeing an Out of Network Provider and I will be using my Out of network Benefits. I further understand that if I receive any payments from my insurance company; I will endorse the checks and forward the payment to your practice.

I authorize my insurance benefits be paid directly to Ear, Nose and Throat Center of NJ.

I authorize Ear, Nose and Throat Center of NJ to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

Patient Signature _____ Date _____

PATIENT CONSENT FORM
(HIPPA)

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice; you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used and disclosed for treatment, payment or health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your Consent. The practice provides this form to comply with the health Insurance Portability and Accountability Act of 1966 (HIPPA).

The patient understands that:

- This consent also confirms the receipt of the Privacy Notice of the medical practice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

Signature: _____ **Date:** _____

Relationship to patient (if other than patient): _____

Consent was taken by: _____
(Office Representative)

EAR NOSE & THROAT CENTER OF NEW JERSEY, PA
HIPPA PRIVACY

The Privacy Rule for healthcare providers use to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the Individual. Healthcare entitled must keep records of PHI disclosures. Information provided, if completed properly, will constitute and adequate record.

Notes: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Please list names and numbers of any immediate family members to which you are allowing us to discuss medical condition with.

Name	Telephone	Relationship

Patient Signature

Date

EAR NOSE & THROAT CENTER OF NEW JERSEY, PA

Patient Name/Nombre:_____ Date of Birth/Fecha de Nacimiento:_____
Age/Edad: _____ Height/Altura: _____ Weight/Peso: _____ Blood Pressure/Presion Arterial: _____
What Is The Reason For Your Visit?/Razon Por La Visita?_____
Referring Doctor (Name):_____

How Did You Hear About US?
☐ Google ☐Insurance ☐Friend ☐Newspaper ☐Walked By TV Commercial: ☐Comcast ☐Cablevision ☐Channel 12 News

Symptoms: (Check ☐ All That Applies)

General
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Sweats
☐ Headache
☐ Numbness
☐ Nervousness
☐ Loss of Weight
☐ Loss of Sleep
☐ Earache

Eye, Ear, Nose, Throat
☐ Bleeding Gum
☐ Blurred Vision
☐ Crossed Eyes
☐ Nose Bleeds
☐ Double Vision
☐ Loss of Hearing
☐ Snoring
☐ Ringing in Ears
☐ Sinus Problems
☐ Hoarseness
☐ Persistent Cough
☐ Difficulty Swallowing
☐ Hay Fever
☐ Ear Discharge

Gastrointestinal
☐ Acid Reflux
☐ Appetite
☐ Bloating
☐ Bowl Changes
☐ Constipation
☐ Digestion
☐ Gas
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood
☐ Rectal Bleeding
☐ Nausea
☐ Hemorrhoids
☐ Excessive Thirst
☐ Excessive Hunger

Muscle/Joint/Bone
☐ Arms
☐ Back
☐ Feet
☐ Hands
☐ Hips
☐ Legs
☐ Neck
☐ Shoulders

Cardiovascular
☐ Bruise Easily
☐ Change in Moles
☐ Chest Pain
☐ Hives
☐ Irregular Heart Beat
☐ Itching
☐ Low Blood pressure
☐ Poor Circulation
☐ Rapid Heart Beat
☐ Rash
☐ Scars
☐ Sore That Won't Heal
☐ Swelling of Ankles
☐ Varicose Veins

Occupational
Check if Your Work Exposes You To:
☐ Stress
☐ Radiation
☐ Loud Noise Exposure
☐ Hazardous Substance
☐Occupation:_____

Health Habits
Check All That Applies
☐ Alcohol: How Much _____
☐ Caffeine: How Much _____
☐ Street Drugs:_____
☐ Tobacco/Smoking:
How Much _____
☐ Other:_____

Conditions (Check ☐ All That Applies)
☐ ADD
☐ ADHD
☐ Aids
☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autism
☐ Bleeding Disorder
☐ Bronchitis
☐ Other:_____
☐ Cancer
☐ Central Auditory Processing
☐ Chemical Dependency
☐ Chronic Sinusitis
☐ Diabetes
☐ Down Syndrome
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ High Cholesterol
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Meniere's Disease
☐ Migraine Headaches
☐ Miscarriage
☐ Multiple Sclerosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Psychiatric Care
☐ Reflux
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Sleep Apnea
☐ Speech Delay
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers

Surgeries:

Year	Hospital	What Type of Surgery Was Performed

Pharmacy Name: _____ Pharmacy Number: _____-_____-_____

Medications:

Allergies:

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

For Office Use Only: Reviewed With Patient By:	
Dr. Oliver:_____ Dr. Jan:_____	