



PATIENT REGISTRATION

Please PRINT clearly and legibly in ink

Date: \_\_\_\_\_

\*Please present insurance card & photo ID\*

Last Name: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Doctors Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth (M/D/YY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_  ok leave msg

Gender:  Male  Female Age: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_  ok leave msg

Marital Status:  Married  Single  Divorce  Widow

Work Phone: (\_\_\_\_) \_\_\_\_\_  ok leave msg

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employment Status:

Student PT\_\_ FT\_\_  Unemployed  Retired  Disabled  Employed PT\_\_ FT\_\_  NA (minor)

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is your visit workers comp or auto related?  Yes  No

Emergency Contact Information

Relation to Patient \_\_\_\_\_

Name: \_\_\_\_\_

check if address/phone are same as patient

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Other: \_\_\_\_\_

Who referred you to our practice?

Primary Doctor (name) \_\_\_\_\_

Other Doctor (name) \_\_\_\_\_

Insurance Plan (name) \_\_\_\_\_

Friend/Family (name) \_\_\_\_\_

Internet (website name) \_\_\_\_\_

Yellow Pages \_\_\_\_\_

Advertisement (paper) \_\_\_\_\_

Other (please specify) \_\_\_\_\_

Are any of your family members existing patients?

If so, please list name and DOB: \_\_\_\_\_

\_\_\_\_\_



# PATIENT REGISTRATION

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### Responsible Party Information

check if same as patient

Name: \_\_\_\_\_

Relation of Patient to named: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

check if address/phone are same as patient

Gender:  Male  Female

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

### Insured's (Main Card Holder) Information

check if same as patient

Name: \_\_\_\_\_

Relation to Patient to insured: \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

check if address/phone are same as patient

Gender:  Male  Female

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Other: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Email address: \_\_\_\_\_

May we contact you via email?  Yes  No

### If you have a secondary address, please enter below:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Pharmacy (we prescribe electronically so your prescription will be sent directly to the pharmacy:

Preferred Pharmacy: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

(shopping plaza or cross streets if address not known)



## **Consent to Treat, Release of Information, Assignment of Benefits & Financial Responsibility**

I hereby give my consent to all physicians and health care providers of ENT & Facial Plastic Surgery Specialists, P.L. to provide treatment to the named patient.

I hereby authorize ENT & Facial Plastic Surgery Specialists, P.L. physicians and staff to obtain all necessary medical records from other doctor's offices, hospitals, clinics, surgery centers and laboratories. I hereby give my consent to use my individual identifiable information as needed in the course of routine health care operations. I hereby authorize ENT & Facial Plastic Surgery Specialists, P.L. to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed.

I hereby consent to allow a photocopy of my signature to be valid as the original, in order to process my current and any future Insurance / Medicare claims. I hereby assign Insurance / Medicare benefits to be paid directly to ENT & Facial Plastic Surgery Specialists, P.L.

I understand that I am financially responsible for all charges incurred during the course of treatment, whether or not paid by any insurance. I am aware that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

I understand that insurance companies sometimes deny claims because of lack of information on the patient's part and will not pay these claims until the patient gives this information to them. If my insurance company has denied the claim because I have not given the information that they need to pay the claim, ENT & Facial Plastic Surgery Specialists, PL may transfer the balance to my responsibility.

I understand that if I am required to obtain a prior authorization for care and do not obtain that authorization, ENT & Facial Plastic Surgery Specialists, PL may transfer the balance to my responsibility.

I agree and understand that if payment is more than **60** days late, without having made any payments or payment arrangements, my account may be sent to collections. I understand that should my account be in default, ENT & Facial Plastic Surgery Specialists, PL may be entitled to interest, collection, and/or attorney fees as allowed by Florida law.

I understand that there is a \$30.00 fee for any check returned by the bank for any reason. I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is acknowledgement and acceptance of this policy and its terms and conditions.

*It is our goal to provide you with excellent care, both medically and professionally. We request your cooperation and appreciate your prompt attention to this matter.*

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Person responsible for any balance not covered by insurance:** \_\_\_\_\_

**Responsible Party Signature:** \_\_\_\_\_

## Notice of Privacy Practices Acknowledgement

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and I may contact this organization at any time to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at home. You may contact me or leave a voice message at home and at any other numbers I provide on the registration sheet.

However, **do NOT leave a message** at the following telephone numbers: \_\_\_\_\_  
However, **do NOT call at all** at the following telephone numbers: \_\_\_\_\_

You may discuss any portion of my medical record with the following people:

(name) \_\_\_\_\_ (relationship) \_\_\_\_\_ Expiration Date\*: \_\_/\_\_/\_\_

(name) \_\_\_\_\_ (relationship) \_\_\_\_\_ Expiration Date\*: \_\_/\_\_/\_\_

(name) \_\_\_\_\_ (relationship) \_\_\_\_\_ Expiration Date\*: \_\_/\_\_/\_\_

\*if no date indicated, default expiration date of 12/31/2025 will be used

**Signature:** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

*(If patient under 18 years old, must be signed by a parent or guardian.)*

**Date:** \_\_\_\_\_

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### OFFICE USE ONLY

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I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form but was unable to do so as documented below:

Date:	Initials:	Reason:
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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary reason for today's visit: \_\_\_\_\_

Allergies (write "no" if none): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Medications (write "no" if none) only list the names, do NOT need dose: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Age: \_\_\_\_\_  
 Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_

Check all that apply:

*Other Medical Conditions*

High Blood Pressure  
 Bleeding Disorder  
 Glaucoma  
 Diabetes  
 Stroke  
 Thyroid Disease  
 Sleep Apnea  
 Asthma  
 Cancer (of \_\_\_\_\_ )  
 Poor Circulation  
 Heart Disease  
 Other: \_\_\_\_\_

Check all that apply:

*Past Surgeries*

Tonsillectomy  
 Adenoidectomy  
 Thyroidectomy  
 Ear Surgery  
 Sinus Surgery/Turbinate Surgery  
 Nasal Septoplasty  
 Carotid Artery Surgery  
 Ear Tubes  
 Pacemaker  
 Heart Bypass / Valve  
 Other: \_\_\_\_\_

Check all that apply:

*Family History of Illness*

High Blood Pressure  
 Bleeding Disorder  
 Glaucoma  
 Diabetes  
 Stroke  
 Thyroid Disease  
 Hearing Loss  
 Vertigo  
 Cancer (of \_\_\_\_\_ )  
 Poor Circulation  
 Heart Disease  
 Other: \_\_\_\_\_

*How often do you use Alcohol?*

Never  
 Occasionally  
 Daily: How Much ?

*Did you ever chew Tobacco?*

Never did  
 Yes  
 Quit: When?

*Did you ever Smoke?*

Never did  
 Yes: \_\_\_ packs per day for \_\_\_ years  
 Quit: When?

Review of Systems: Do you have any of these symptoms? Please check *yes* or *no* to each item...

		Yes	No
General	fever	<input type="checkbox"/>	<input type="checkbox"/>
	weight loss	<input type="checkbox"/>	<input type="checkbox"/>
	night sweats/chills	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
Ear, Nose & Throat	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>
	loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
	throat pain	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	
snoring	<input type="checkbox"/>	<input type="checkbox"/>	

		Yes	No
Cardiac	chest pain when walking	<input type="checkbox"/>	<input type="checkbox"/>
	swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
	blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Lung	cough	<input type="checkbox"/>	<input type="checkbox"/>
	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
	blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	excessive sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
	excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
	in ability to sleep	<input type="checkbox"/>	<input type="checkbox"/>
Heme/L	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
	blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	sneezing	<input type="checkbox"/>	<input type="checkbox"/>
	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
	history of allergy shots	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
	double vision	<input type="checkbox"/>	<input type="checkbox"/>
	excessive tears	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
Muscle	neck pain	<input type="checkbox"/>	<input type="checkbox"/>
	joint pains	<input type="checkbox"/>	<input type="checkbox"/>
	pain in jaw with chewing	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	numbness	<input type="checkbox"/>	<input type="checkbox"/>
	paralysis/weakness	<input type="checkbox"/>	<input type="checkbox"/>
	headache	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	depression	<input type="checkbox"/>	<input type="checkbox"/>
	anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Skin	rash	<input type="checkbox"/>	<input type="checkbox"/>
	ulcers/growths	<input type="checkbox"/>	<input type="checkbox"/>
	discoloration	<input type="checkbox"/>	<input type="checkbox"/>
GI	heartburn	<input type="checkbox"/>	<input type="checkbox"/>
	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	nausea	<input type="checkbox"/>	<input type="checkbox"/>
GU	difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
	might you be pregnant now	<input type="checkbox"/>	<input type="checkbox"/>

Patient (or Guardian) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_