EAR, NOSE & THROAT ASSOCIATES OF NORTHERN COLORADO, P.C.

REGISTRATION INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY #

DATE OF BIRTH	AGE	M / F	RACE	MARITAL STATUS (CIRCLE ONE) S M D W	SPOUSE'S NAME (**IF APPLICABLE**)

MAILING ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE # HOME CELL WORK **IS IT OKAY TO LEAVE VOICEMESSAGES YES / NO**

CURRENTLY WORKING? **YES** **NO** **PATIENT'S CURRENT EMPLOYER & PHONE NUMBER**

EMPLOYERS ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS (USED TO CREATE YOUR PATIENT PORTAL)

RESPONSIBLE PARTY IF OTHER THAN PATIENT – RELATIONSHIP	**EMPLOYER OF RESPONSIBLE PARTY**

MAILING ADDRESS OF RESPONSIBLE PARTY **(IF DIFFERENT FROM ABOVE)**	CITY	STATE	ZIP CODE

PATIENT'S PRIMARY INSURANCE	RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)
POLICY HOLDER'S NAME	POLICYHOLDER'S DOB AND SS#
PATIENT'S SECONDARY INSURANCE (IF APPLICABLE)	RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)
POLICY HOLDER'S NAME	POLICYHOLDER'S DOB AND SS#

IN CASE OF AN EMERGENCY, NOTIFY:

NAME	**PHONE**	**RELATIONSHIP**

Have you or any member of your family ever been treated in this office? YES NO

If so, when?_____ **Name:**_____ **Relation:**_____

Referral Type (PLEASE CHECK ONE): ☐ Dex Yellow pages ☐ Dex Knows Online ☐ The Yellow Book **(NOT YELLOW PAGES)**

☐ Friend: _____ ☐ Physician/Medical Facility:_____ ☐ Internet Search:_____ ☐ Other:_____

ASSIGNMENT OF BENEFITS AND NOTICE OF PATIENT INFORMATION PRACTICES

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to Ear, Nose and Throat Associates of Northern Colorado, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. IN THE EVENT MY INSURANCE REQUIRES A REFFERAL, AND I DO NOT PROVIDE ONE AT THE TIME OF SERVICES, I AM RESPONSIBLE FOR ANY CHARGES INCURRED. I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all medical and pharmacy records to ENT Associates of Northern Colorado and my primary and referring physicians. I hereby authorize release of copies of this information sheet to any hospital I may be admitted to. I also authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim. I acknowledge receipt of the Notice of Patient Information Practices. I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES and I am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice. I understand that I may request, in writing, restrictions to the use or disclosure of my protected health records, and that I am able to provide access to my personal health information by written authorization.

_____

SIGNATURE DATE

PATIENT HISTORY SHEET

PATIENT NAME:_____ DATE OF BIRTH:_____ TODAY'S DATE:_____

NAME AND LOCATION OF YOUR PHARMACY: _____

PRIMARY CARE PHYSICIAN OR REFERRING DOCTOR: _____

CURRENT MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS)**:**

MEDICATIONS ALLERGIES: YES NONE (**UNKNOWN**)

ENVIRONMENTAL/SEASONAL ALLERGIES
(INCLUDING LATEX, CONTACT ALLERGIES)**:** YES NONE (**UNKNOWN**)

FOOD ALLERGIES: YES NONE (**UNKNOWN**)

PLEASE INDICATE ALL ILLNESSES AND HEALTH PROBLEMS FOR BOTH YOURSELF AND YOUR <u>IMMEDIATE</u> FAMILY.
(CHECK APPROPRIATE BOX)

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
CANCER	☐	☐	☐	☐	
ASTHMA	☐	☐	☐	☐	
LUNG DISEASE/ COPD	☐	☐	☐	☐	
DIABETES	☐	☐	☐	☐	
HEART ATTACK	☐	☐	☐	☐	
HEART DISEASE	☐	☐	☐	☐	
HEART MURMUR	☐	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	☐	
RINGING IN THE EARS	☐	☐	☐	☐	
HEARING LOSS	☐	☐	☐	☐	
THYROID PROBLEMS	☐	☐	☐	☐	
WEIGHT LOSS	☐	☐	☐	☐	
ARTHRITIS	☐	☐	☐	☐	
DIZZINESS	☐	☐	☐	☐	
MIGRAINES	☐	☐	☐	☐	

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
KIDNEY PROBLEMS	☐	☐	☐	☐	
FEVERS	☐	☐	☐	☐	
PROSTATE OBSTRUCTION	☐	☐	☐	☐	
STROKE	☐	☐	☐	☐	
TUBERCULOSIS	☐	☐	☐	☐	
POLIO	☐	☐	☐	☐	
GLAUCOMA	☐	☐	☐	☐	
NERVE OR PSYCHIATRIC DISEASE	☐	☐	☐	☐	
UNUSUAL CHILDHOOD DISEASE	☐	☐	☐	☐	
STOMACH ULCERS/ HEART BURN	☐	☐	☐	☐	
NECK PROBLEMS	☐	☐	☐	☐	
BLEEDING PROBLEMS	☐	☐	☐	☐	
HPV	☐	☐	☐	☐	
HIV VIRUS	☐	☐	☐	☐	
HEPATITIS type: _____	☐	☐	☐	☐	

OTHER ILLNESSES AND HEALTH PROBLEMS NOT LISTED: _____

OTHER PHYSICAL RESTRICTIONS: _____

PLEASE LIST ALL SURGERIES: _____

IMMUNIZATIONS: UP TO DATE? ☐ **YES** ☐ **NO** **IMMUNIZATIONS FOR:** ☐ **FLU** ☐ **SHIINGLES** ☐ **PNEUMONIA** **YEAR:**_____

DO YOU USE TOBACCO? ☐ **CURRENT** ☐ **FORMER** ☐ **NEVER**

DO YOU USE ALCOHOL? ☐ **CURRENT** ☐ **FORMER** ☐ **NEVER**

DO YOU USE ASPIRIN? ☐ **DAILY** ☐ **SOMETIMES** ☐ **NEVER**

RECREATIONAL DRUGS? ☐ **CURRENT** ☐ **FORMER** ☐ **NEVER**

Ear, Nose and Throat Associates of Northern Colorado Financial and Contact Policy

Welcome to Ear, Nose and Throat Associates of Northern Colorado, P.C. Please take a few minutes to review the following information.

PATIENT RESPONSIBILITIES:

Co-payments: We do not bill for copayments. Co-payments are due at the time of service.

Referrals: If your insurance requires a referral and you do not provide one at the time of service, you are responsible for any charges incurred.

Cancellations: A $25.00 cancellation fee will be assessed if the appointment is not cancelled 24 hours in advance.

Return Checks: A $20.00 fee will be assessed on returned checks.

If you have health insurance with which we participate:

- We will bill your insurance claim for you and we expect any required copayment at the time of service

If we do not participate with your insurance:

- We will do a courtesy billing for you and we expect payment of deductibles and/or coinsurance to be paid in full at the time of service

MEDICAID PATIENTS:

- If services provided are not a covered benefit you will be responsible for any charges incurred.

If you do not have insurance, we expect payment at the time of service. We accept **VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER and CARE CREDIT** (3-month plan).

Surgical deductibles will be collected prior to surgery. Balances are due after a statement has been issued. If payment arrangements need to be made, payment in full must be within 90 days. A one-time $25.00 rebilling fee will be assessed to accounts after 90 days. Accounts over 90 days are subject to collection. If your account is placed in full collection or if we write off a bad debt you will be dismissed from this practice. Refunds will be returned in the same form tendered.
I have read and agree to the above.

Date: _____ **Signature:** _____

Print Name: _____

You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or e-mails, using an e-mail address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I/We have read this disclosure and agree that we may be contacted as described above.

Date: _____ **Signature:** _____

Release of (Medical) Records

I authorize this clinic to furnish medical information regarding the treatment of my current injury/illness to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related injuries).

Date: _____ **Signature:** _____

Ear, Nose and Throat Associates of Northern Colorado

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any preotected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated party/parties must be verified before the release of any information.

Patient name:_____

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Print name (If the patient is a minor, parent/guardian's name and relationship)

_____

Signature Date