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

REGISTRATION INFORMATION

PAITENT'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

E-MAIL ADDRESS PATIENT'S CURRENT EMPLOYER

CURRENTLY WORKING? YES NO

EMPLOYERS ADDRESS CITY STATE ZIP CODE PHONE #

IN CASE OF AN EMERGENCY, NOTIFY RELATIONSHIP TO PATIENT PHONE #

RESPONSIBLE PARTY EMPLOYER

MAILING ADDRESS CITY STATE ZIP CODE

PRIMARY INSURANCE RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)

POLICY HOLDER'S NAME POLICYHOLDER'S DOB AND SS#

SECONDARY INSURANCE RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)

POLICY HOLDER'S NAME POLICYHOLDER'S DOB AND SS#

PATIENT'S PRIMARY CARE PHYSICIAN

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 the 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.

_____

SIGNATURE DATE

PATIENT HISTORY SHEET

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

NAME AND LOCATION OF THE PHARMACY THAT YOU USE: _____

PRIMARY CARE PHYSICIAN OR REFERRING DOCTOR: _____

CURRENT MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS):

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS: YES NONE (UNKNOWN)

_____

_____

_____

ENVIRONMENTAL
(INCLUDING LATEX OR CONTACT ALLERGIES): YES NONE (UNKNOWN)

_____

_____

_____

FOOD ALLERGIES: YES NONE (UNKNOWN)

_____

_____

_____

PLEASE INDICATE ALL PREVIOUS ILLNESSES AND HEALTH PROBLEMS FOR BOTH YOURSELF AND YOUR FAMILY.
(CHECK APPROPRIATE BOX)

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
CANCER	☐	☐	☐	☐	_____
ASTHMA OR LUNG DISEASE	☐	☐	☐	☐	_____
DIABETES	☐	☐	☐	☐	_____
CHEST PAIN WITH EXERCISE	☐	☐	☐	☐	_____
HEART ATTACK	☐	☐	☐	☐	_____
HEART DISEASE	☐	☐	☐	☐	_____
HEART MURMUR	☐	☐	☐	☐	_____
HIGH BLOOD PRESSURE	☐	☐	☐	☐	_____
RINGING IN THE EARS	☐	☐	☐	☐	_____
HEARING LOSS	☐	☐	☐	☐	_____
THYROID PROBLEMS	☐	☐	☐	☐	_____
FEVERS	☐	☐	☐	☐	_____
WEIGHT LOSS	☐	☐	☐	☐	_____
YELLOW JAUNDICE	☐	☐	☐	☐	_____
HEPATITIS	☐	☐	☐	☐	_____

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
KIDNEY PROBLEMS	☐	☐	☐	☐	_____
BLEEDING PROBLEMS	☐	☐	☐	☐	_____
PROSTATE OBSTRUCTION	☐	☐	☐	☐	_____
STROKE	☐	☐	☐	☐	_____
TUBERCULOSIS	☐	☐	☐	☐	_____
POLIO	☐	☐	☐	☐	_____
GLAUCOMA	☐	☐	☐	☐	_____
NERVE OR PSYCHIATRIC DISEASE	☐	☐	☐	☐	_____
UNUSUAL CHILDHOOD DISEASE	☐	☐	☐	☐	_____
ULCER OR STOMACH DISEASE	☐	☐	☐	☐	_____
NECK PROBLEMS	☐	☐	☐	☐	_____
ARTHRITIS	☐	☐	☐	☐	_____
DIZZINESS	☐	☐	☐	☐	_____
HEADACHES	☐	☐	☐	☐	_____
HIV VIRUS	☐	☐	☐	☐	_____

OTHER PHYSICAL RESTRICTIONS: _____

_____

ALL PREVIOUS SURGERIES, INCLUDING THE YEAR: _____

_____

_____

_____

IMMUNIZATIONS: UP TO DATE? YES NO **PATIENTS OVER 65 YEARS OLD:** IMMUNIZATIONS FOR: FLU SHIINGLES PNEUMONIA

DO YOU USE TOBACCO?
YES NO NEVER
IN THE PAST OR PRESENT?

DO YOU USE ALCOHOL?
YES NO NEVER
IN THE PAST OR PRESENT?

DO YOU USE ASPIRIN?
YES NO NEVER
IN THE PAST OR PRESENT?

RECREATIONAL DRUGS?
YES NO NEVER
IN THE PAST OR PRESENT?

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: _____