Patient Demographics/Insurance Authorization

Patient's Name | Male Female Gender (circle one) | Today's Date

Street Address | Apt. #

City | State | ZIP Code | Date of Birth | Age

Social Security # of Patient | Patient's or Guarantor's email address

Home Phone | Cell Phone | Work Phone

Emergency Contact Person | Relationship to Patient | Contact #

Employer's Name | Address | Phone #

Insurance Company Name | Policy # | Group #

If HMO, Name of Primary Care Physician (PCP)

Is the Patient the Policy Holder? (circle one) Yes No If no, complete the next 3 lines

Name of Insured | Relationship to Patient

Address of Insured (if not the same as above)

Social Security # of Insured | Date of Birth of Insured

Secondary Insurance Company (if any) | Policy # | Group #

Person Responsible for Payment (Guarantor, if other than patient) | Date of Birth | Social Security #

Guarantor's Address | Phone #

Guarantor's Employer | Work Phone #

I authorize release of medical information to Medicare or other insurance companies pertaining to my history, services rendered or treatment given to me or my dependents for purposes of claims review. I request that Medicare or other insurance companies make payments on my behalf directly to Dr. Spingarn. I am responsible for paying copayments at the time of service, if required by my insurance. I acknowledge and accept final responsibility for payment of all charges. If I do not pay all charges, I understand that my account may be sent to a collection agency and that an additional charge of 30% of the unpaid amount will be added to the bill as a collection fee. I am aware that tests sent to an outside laboratory may result in additional charges billed to me by the lab.

Signature | Date

WESTCHESTER E.N.T.
PATIENT SELF ASSESSMENT FOR INITIAL VISIT

We ask that all of our patients fill out this form at the time of their first visit to our office. Please do your best to answer all the questions. If you do not understand a question, your doctor or nurse can explain it. These questions are meant to help us take care of you. Everything is CONFIDENTIAL and will become part of your medical record.

What is your name?_____ Today's Date?_____
Your date of birth? _____
What brings you in today?_____

If you have a regular doctor, please list his or her name, address and phone number:_____
_____
How did you hear about our
practice?_____

Current Problems:

Do you have any illnesses or medical conditions now? □ YES □ NO
If yes, please list them:_____
_____

Past Medical History: Have you ever had any of the following? (please check all that apply)

□ Cancer □ High blood pressure □ Stroke □ Diabetes □ Asthma/Allergy □ Depression
□ Arthritis □ Acid Reflux □ Heart disease □ Serious Injury □ Hepatitis □ Substance Abuse

Have you ever been hospitalized? □ YES □ NO If yes, list when and why:
_____
_____

Have you ever had an operation? □ YES □ NO If yes, please list type of surgery and year (include tonsils)
_____
_____

MEDICATIONS:

List all your medications and doses:

	Name	Dose	Route	How often do you take it?
EXAMPLE:	Tylenol	650 mg	oral	Four times daily

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any vitamins, herbs, supplements, or over the counter medications you take, even if you use them only rarely:

Allergies:

Do you have any allergies to medications? □ YES □ NO If yes, what?_____
Do you have any allergies to food? □ YES □ NO If yes, what? _____

Family History:

Do any of your family members have or did they have in the past?

□ Diabetes □ Depression □ Stroke □ High Blood Pressure □ Alcoholism □ Cancer
□ Heart disease □ Heart attack □ Asthma □ Tuberculosis □ Thyroid disease □ Glaucoma

Details regarding the health of your family:

	Age or Age at Death	Medical problems or cause of death
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____
	_____	_____

Do you have a preferred pharmacy? If yes, please write the name, address and phone number:
_____

(Please turn over and complete the other side)

Name:_____ Date of Birth:_____

Social History: (please check all that apply)

□You smoke cigarettes □You smoked cigarettes in the past □ Anyone you live with or work closely with smokes

□You drink alcohol currently □ You drank alcohol in the past

□You use any drugs (for example: marijuana, cocaine, heroin) □ You used drugs in the past

□You have any religious or cultural beliefs that your doctor should know about before beginning medical treatment

What is your occupation? _____ What is the last grade in school you completed? _____

REVIEW OF SYSTEMS: Do you currently have any of the following? (please check all that apply)

Constitutional:
□ Recent weight change of more than 10 pounds
□ Worry/ preoccupation with weight
□ Decreased appetite
□ Frequent fevers/ night sweats
□ Fatigue/ weakness
□ Difficulties sleeping
□ Special diet
□ Excessive daytime sleepiness

Eyes:
□ Wear glasses/ contact lenses
□ Blurred or double vision
□ Burning/ itching/ watery eyes
□ Pain/ redness

Ears, Nose, and Throat:
□ Difficulty hearing
□ Ringing in the ears/Tinnitus
□ Pain in the ears
□ Drainage from the ears
□ Dizziness
□ Off balance or unable to tolerate motion
□ Stuffy nose
□ Nose bleeds
□ Diminished sense of smell or taste
□ A lot of mucus when you blow your nose
□ Nose feels too dry or burning
□ Runny nose
□ Post-nasal drip
□ Too much phlegm in your throat
□ Sinus headaches
□ Snoring
□ Waking up choking or gasping for breath
□ Mouth sores
□ Hoarseness/changes in your voice
□ Difficulty swallowing or choking on your food
□ Painful swallowing
□ Chronic/ frequent coughing
□ Current sore throat
□ History of chronic/ recurrent sore throats
□ Feeling something is stuck in your throat/ frequent throat clearing
□ Throat feels too dry or burning
□ Dental problems
□ Bad breath
□ Tongue film
□ Considering Botox injections/fillers

Endocrine:
□ Goiter now or in past
□ Bothered excessively by hot or cold weather
□ Excessive sweating
□ Thirsty most of the time
□ High blood sugar

Hematologic/ Lymphatic:
□ Bleeding/ bruising easily
□ Lumps in neck, armpits, groin
□ Low blood count in past

Allergic/Immunologic:
□ Recurrent infections
□ Allergies or hay fever
□ Frequent sneezing

Neurological:
□ Frequent headache
□ Numbness, pain or tingling of arms or legs
□ Muscle weakness
□ Convulsions/ seizures
□ Memory problems
□ History of mini strokes

Psychiatric:
□ Hospitalized for mental or nervous disorder
□ Depressed or sad
□ Nervous or anxious
□ Excessive stress
□ Sleep problems

Musculoskeletal:
□ Painful or swollen joints
□ Trouble with your back
□ Difficult or painful walking
□ Fell down within the last year
□ Pain/stiffness in your neck

Respiratory:
□ Shortness of breath
□ Coughing up blood
□ Dry cough
□ Wet (productive) cough

Gastrointestinal:
□ Black or bloody stools
□ Hemorrhoids
□ Nausea/vomiting
□ Diarrhea
□ Constipation or use of laxatives
□ Change in bowel habits
□ Abdominal pain/ heartburn

Genitourinary:
□ Frequent urination
□ Urinating frequently at night
□ Burning or pain on urination
□ Blood in urine
□ Difficulty holding urine
□ Sexual dysfunctions

Skin:
□ Rashes or itching
□ Change in skin color
□ Moles on your face, neck or scalp
□ Lumps under the skin of the face, neck or scalp

Cardiovascular:
□ Palpitations/feeling like your heart is racing
□ Chest pain/ tightness
□ Fainting
□ Swelling of feet/legs
□ Irregular heart beat
□ Heart murmur
□ Unable to climb 2 flights of stairs

Women:
□ Vaginal bleeding between periods or after intercourse
□ Vaginal discharge or lesions
□ Discharge or lump in breast

Men:
□ Discharge or drip from penis
□ Sore or lump near or on penis
□ Lump on testicles

Notice of HIPAA Privacy Practices

A copy of this policy can be given to you upon request.

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices, and consent to share my health information for payment and treatment purposes.

_____ _____
Patient/Personal Representative Signature Date

_____ _____
Representative's Relationship to Patient Date

_____Patient unable to sign

_____Patient refuses to sign

_____ _____
Employee Signature Date

Westchester ENT

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure, or insurance payment for a procedure but not an office visit. In such cases, payment for the procedure (or the office visit) will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

- Flexible Laryngoscopy: This procedure involves passing a long thin flexible fiberoptic scope through the nasal cavity and into the throat. The fiberoptic scope enables the physician to visualize areas of the throat not readily seen during a standard examination.

- Nasal Endoscopy: This procedure uses the flexible or rigid scope to view areas of the nasal cavities that cannot be viewed by the physician using a standard nasal speculum.

- Nasal Endoscopy with Debridement or Biopsy: This is the same procedure as above with removal of crusting or tissue.

- Cerumen Removal: Cleaning of earwax from the ear canals.

Please speak with our office manager or medical assistant if you have any questions.

_____ _____

Patient Signature: Date:

Informed Consent to E-mail Communication

I consent to receiving E-mail communication from Dr. Aaron Spingarn.

I understand that all E-mail messages are sent over the internet. Messages sent over the internet are not encrypted, are not secure and may be accessed by others. I understand that my E-mail communications with Dr. Spingarn will not be encrypted and Dr. Spingarn can not guarantee the confidentiality and security of any information that I send to Dr. Spingarn or that Dr. Spingarn sends to me via E-mail. I hereby give permission for Dr. Spingarn and his staff to reply to my messages via E-mail and to include any information that would be considered confidential that Dr. Spingarn deems appropriate. I agree that Dr. Spingarn and any employee or agent of Dr. Spingarn shall not be liable for any breach of confidentiality that may result from his use of E-mail via the internet.

I understand and agree that E-mail communication should not be used for urgent or sensitive medical matters since technical or other factors may prevent a timely answer and confidentiality cannot be guaranteed. If I believe that I need a response within 48 hours, I will not use E-mail but will call Dr. Spingarn. If I do not receive an answer to a routine E-mail message within 2 working days, I understand that I should call Dr. Spingarn. I understand that all E-mail communications may be made part of my permanent clinical record and may, therefore, be accessible to Dr. Spingarn, any future staff or doctors working with him, and to anyone to whom Dr. Spingarn or his office provides a copy of my clinical record whether pursuant to a request by me or under applicable law.

I also understand that I should only E-mail Dr. Spingarn from the E-mail address that I have listed below since Dr. Spingarn can not confirm my identity through another person's E-mail address. I understand that it is my responsibility to notify Dr. Spingarn in writing of any change of the E-mail address listed below.

I also understand that I may withdraw permission for Dr. Spingarn to communicate with me via E-mail by notifying Dr. Spingarn in writing.

_____
Patient Name

_____
Signature

_____
Date

_____
E-mail address