PATIENT REGISTRATION

If The Patient Is A Child, Fill Out The Information As It Pertains To The Child

Date: _____

Patient First Name_____ Last Name_____ M.I.____
(As on insurance card) (As on insurance card)

❑ Male ❑ Female Date of Birth ___/___/___ Age____ Social Security # _____ ____ _____

Street _____ City_____ State____ Zip_____

Home Tel. # (___) _____ Business Tel. # (___) _____ Cell Phone # (___) _____

Email Address: _____

***Select ONE contact method for appointment reminders*? Email:** ☐ **Text:** ☐ **Phone Call:** Home ☐ Work ☐ Cell ☐

❑ **Opt out of Promotional emails. To opt out of promotional emails at any time, please call 203-830-4700**

Race: White
African American
Asian
Multi-racial
Refuse to answer

Preferred Language: English
Spanish
Refuse to answer

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Refuse to answer

Primary Doctor_____ Location (City/State) _____

Was this your referring physician? ☐ NO ☐ YES If No, Who was your referring provider? _____

Financially Responsible Person (Guarantor): ☐ **Self** (if NOT self, complete fields below)

Name: _____ Date of Birth ___/___/___ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact Name: _____ Relationship _____

Home Tel #: _____ Cell # _____

☐ By checking, you authorize Advanced Specialty Care to discuss your medical information with the emergency contact listed above.

If your insurance plan requires an insurance authorization referral to this office, you must have this referral at the time of your visit, or full payment will be expected.

It is <u>your</u> responsibility to ensure your authorization referral is <u>current</u> and on file in this office prior to seeing the physician for all visits, including follow-ups. There are <u>NO</u> exceptions to the office referral policy.

***HSA POLICY-If you have a health savings account insurance plan, and your deductible has not been met, we request payment at time of service. For self-pay patients and those with HSA policies, payment is expected at time of service and a payment plan can be discussed with our billing department if needed**Your office visit can range anywhere from $150-$375, to additional testing ranging from $200-$1200.**

IS TODAY'S VISIT RELATED TO AN INJURY, ACCIDENT OR 3RD PARTY PAYER? ☐ **NO** ☐ **YES**

PRIMARY INSURANCE COMPANY INFORMATION

Information must be filled in completely, even if we copy your insurance card.

Ins. Co. Name_____ Plan _____

ID# _____ Group name or Number_____

Policy Holder's Name _____ Relation to patient _____

Sex: ❑ Male ❑ Female Date of Birth ___/___/___ Social Security # _____

SECONDARY INSURANCE COMPANY INFORMATION

Ins. Co. Name_____ Plan _____

ID# _____ Group name or Number_____

Policy Holder's Name _____ Relation to patient _____

Sex: ❑ Male ❑ Female Date of Birth ___/___/___ Social Security # _____

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices Informed Consent
Practice Financial Policies
ADVANCED SPECIALTY CARE

Privacy Officer: Jennifer Retter, Privacy Officer (203) 830-4700 ext. 8265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment. Due to HIPAA laws, we are unable to share your medical information with anyone unless you authorize to do so.
I authorize the person(s) listed below to discuss my medical information:

_____ _____
Name & phone number Relationship to Patient

_____ _____
Name & phone number Relationship to Patient

I authorize Advanced Specialty Care staff to leave medical information, including test results, on the following voicemail/answering machines: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ I hereby authorize Advanced Specialty Care to correspond with me/authorized persons via email regarding my medical care.

Release of Records to Electronic Portal: I understand that my signature on this form authorizes Advanced Specialty Care to send my personal medical records to my personal Electronic portal account when verbally requested. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. This authorization is effective indefinitely unless revoked in writing. I would like the following health information to be sent to my portal account:
☐ All records Other:_____

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.
Please initial each statement on line provided:
___ Under certain circumstances, this office may need to request lab reports, radiology reports, other diagnostic test results, and/or medication history from outside facilities in order to provide treatment. At times these facilities may require an authorization to release such records. My signature authorizes the release of these records.

___ I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

___ I understand that I will be charged a $25-$125 NO-SHOW fee if I do not show up at my scheduled appointment. In order to avoid the NO-SHOW fee an appointment needs to be cancelled 24 hours prior.

___ I understand any office procedures/tests done today may fall under a different insurance benefits classification, therefore may require additional out of pocket cost beyond the office visit fee.

<u>If this office does not have a contract with my insurance company, payment must be made at the time of visit</u> unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited. I understand that any unpaid balances 120 days or older will incur $15 per month late fee.

_____ _____
Patient Signature (Parent/Guardian sign if Patient a Minor) Relationship to Patient

_____ _____/_____/_____
Please Print Name Date

_____ _____/_____/_____
Patients Name (if Minor) Patient's date of birth

ENT Intake

Patients Name:_____

Patients Date of Birth:_____

Today's Date:_____

Patient's Height_____ **Weight**_____

Pharmacy Information

Name: _____

Location: _____

Referring MD: _____

Primary Care MD: _____

Please list all medications you are currently taking and dosage (Include prescriptions, non-prescriptions, herbal supplements, etc.)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Allergies to medication: Drug name/Reaction

_____ _____

_____ _____

_____ _____

Latex Allergy ☐ Yes ☐ No

Review of systems: Please circle Yes or No

Painful urination	Yes	No	Heat intolerance	Yes	No
Heart murmur	Yes	No	Voice Change	Yes	No
Depression	Yes	No	Shortness of Breath	Yes	No
Fever	Yes	No	Loss of consciousness	Yes	No
Heartburn	Yes	No	Difficulty Swallowing	Yes	No
Visual Change	Yes	No			

Medical History: Please circle Yes or No

GERD	Yes	No
Sleep Apnea	Yes	No
Asthma	Yes	No
High Blood Pressure	Yes	No
Anemia	Yes	No
Anesthesia Reaction	Yes	No
Diabetes	Yes	No
Pregnant or May be	Yes	No
Deep Vein Thrombosis	Yes	No
Thyroid Disease	Yes	No
Seizure Disorder	Yes	No
Renal Disease	Yes	No
MRSA	Yes	No
Pulmonary Embolism	Yes	No

List any other pertinent medical history:

1._____

2._____

Surgical History

Tonsillectomy	Yes	No
Adenoidectomy	Yes	No
Thyroidectomy	Yes	No
Sinus Surgery	Yes	No
Other	Yes	No

1._____

2._____

Family History: Please circle Yes or No

Blood Disorder **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Deafness **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Thyroid Disorder **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Genetic Disease **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Anesthesia Reaction **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Coronary Artery Disease **Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

Cancer Type:_____**Yes** **No**
Father__Mother__Sister__Brother__Son__Daughter__

List any other pertinent family history:

1. _____

2. _____

Social History:(Smoking status for patients 13 yrs and older)

Have you ever used tobacco? Yes No

Current every day smoker ☐

Current some day smoker ☐

Smoker, current status unknown ☐

Never smoker ☐

Former smoker ☐

Unknown if ever smoked ☐

Do you chew tobacco **Yes** **No**

Do you drink alcohol **Yes** **No**

If yes: Daily__Weekly__Monthly__Yearly

Do you consume caffeine: Yes No

Sleep/ Snoring Questionnaire

First Name:_____ Last Name:_____
Patient's Date of Birth:_____

Please check YES or NO to all the statements.

	YES	NO
1. My family complains about my snoring		
2. People refuse to share a bedroom because of my snoring		
3. Experience loud snoring when sleeping on my back		
4. Experience loud snoring when sleeping on my side		
5. Experience loud snoring even when asleep sitting up		
6. I have been told I stop breathing during sleep		
7. I have been told I choke or gasp during sleep		
8. I wake up with a choking or gasping sensation.		
9. I wake up with my heart beating faster than usual.		
10. Experience nasal congestion, obstruction or discharge at night		
11. Dry mouth upon awakening		
12. Headaches upon awakening		
13. Waking up feeling tired		
14. Feeling exhausted despite sleeping for many hours		
15. Fighting sleepiness during daily activities		
16. Difficulty staying alert when I am required		
17. Decreased concentration		
18. Forgetfulness		
19. Taking more than 30 minutes to fall asleep on most nights		
20. Wake up during night and have hard time falling back asleep		
21. Waking up early and being unable to fall back asleep		
22. Need to use sleep aids or medications		
23. Unable to sleep at all		
24. "Restlessness of Legs" when lying down in bed before sleep		
25. Leg twitches during sleep		
26. Alcohol use before bed		

How likely are you to doze off and fall asleep in the following situations? Even if you have not done some of these things recently, try to remember how you have reacted in the past. Check the most appropriate response for each situation.
Situation:

EPWORTH SLEEPINESS SCALE	Never Doze (0)	Slight Chance of Dozing (1)	Moderate Chance of Dozing (2)	High Chance of Dozing (3)
Sitting and Reading?				
Watching TV?				
Sitting inactive in a public place? (ie: Theatre, Movie, Meeting)				
As a passenger in a car for an hour without a break?				
Lying down to rest in the afternoon at home when conditions permit?				
Sitting and talking to someone?				
Sitting quietly after a lunch without alcohol?				
In a car, While stopped in traffic for a few minutes?				