

PATIENT DEMOGRAPHICS:

Patient Name: _____ Sex: M ___ F ___
Home Address: _____
Date of Birth _____ Age _____
Social Security # (patient) _____
Home Phone # _____ cell # _____
Work # _____ Employer Name: _____

If Patient is UNDER 18- Parent/Guardian Name _____
Parent/Guardian Phone: _____ Social Security # _____

Referring Doctor

Name : _____
Address: _____
Office Phone # : _____

Emergency Contact Person : _____
Relationship to Patient : _____
Contact Phone # _____ cell# _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____
Phone # _____ Group# _____
Policy Holder Name & ID# _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____
Phone# _____ Group# _____
Policy Holder Name & ID# _____

GUARANTOR INFORMATION:

Subscriber Name (policy holder) _____
Subscriber Social Security # _____
Address _____
Date of Birth _____ Relationship to Patient _____
Employer Name _____ Phone # _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of his authorization to be used in place of the original, and request payment of insurance benefits either to myself or the party who accepts assignment.

Name _____ Signature _____ Date _____

I authorize you to remit all medical benefits directly to Rockland Ear Nose and Throat, Associates, P.C.

Name _____ Signature _____ Date _____

Medical Information Form: Page One

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ WEIGHT _____ HEIGHT _____

DOCTOR WHO SENT YOU HERE: _____

1) WHY ARE YOU HERE TODAY?

2) LIST YOUR CURRENT MEDICATIONS (prescription, over-the-counter, vitamins, herbals, aspirin, birth control):

3) DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR LATEX?

4) PAST MEDICAL HISTORY (circle all that apply):

- | | | | |
|------------------------|-------------------------|----------------------------|----------------------|
| Heart disease | Allergy/hay fever | Diabetes/sugar | High blood pressure |
| Alcoholism | Thyroid Problem/Goiter | Mental illness/retardation | Arthritis |
| Depression | Irregular heart beat | Glaucoma | Migraines |
| Asthma/Bronchitis/Lung | Tuberculosis | Bleeding Disorder/Anemia | Urine/kidney disease |
| Stroke | AIDS/HIV | Lyme disease | High cholesterol |
| Epilepsy/seizures | Liver disease/hepatitis | Reflux/ulcer | Bone fractures |
| Osteoporosis | Prostate | Menieres disease | Deafness |
| Otosclerosis | Cancer-where? | Radiation Therapy? | Chemotherapy? |
| Anesthesia Problems? | _____ | | |

5) PAST SURGICAL HISTORY (please list all operations including tonsillectomy & adenoidectomy):

6) SOCIAL HISTORY:

Job description or school grade _____

Are you Single? _____ Married? _____ # of children _____

Do you smoke? _____ Packs a day? _____ # of years? _____ Did you ever smoke? _____ When did you quit? _____ Second hand smoke? _____

How often and how much alcohol do you drink? _____

How many cups of caffeinated beverages per day (coffee, tea or soda) _____

What kind of pets do you have? _____

Are you pregnant? _____ PAP smear less than 3 years ago? _____

Vaccines up-to-date? _____

7) FAMILY HISTORY (circle all that apply):

- | | | | |
|---------------------|---------------------|-------------------|--------------|
| Heart disease | Diabetes/sugar | High cholesterol | Arthritis |
| High blood pressure | Anesthesia problems | Thyroid disease | Migraine |
| Lung disease/asthma | Hay fever/allergies | Bleeding disorder | Anemia |
| Hearing loss | Otosclerosis | Menieres disease | Osteoporosis |
| Alcoholism | Cancer | Mental illness | Epilepsy |

8) OTHER/COMMENTS:

Reviewed by _____

Health Information Form: Page Two

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

9)REVIEW OF SYSTEMS (please circle all that apply):

<u>General symptoms:</u>	Fever Weight change	Night sweats Sleeping problems	Appetite change Born prematurely
<u>Eyes:</u>	Vision changes	Eye infections	Itchy/watery
<u>Ears:</u>	Decreased hearing Ear pain Drainage/odor Trouble popping	Ear infections(#/year) Dizzy spells/vertigo TMJ disorder Q-tip use	Ringing/noises Hearing aids Ear wax
<u>Nose:</u>	Nosebleeds Sneezing/allergies Nasal polyps	Broken/deviated septum Nasal pain Sinus infections(#/year)	Congested Poor sense of smell Post-nasal drip
<u>Mouth/Throat:</u>	Sore throat Mouth lesions Tooth/dental problems	Tonsil infections(#/year) Hoarseness/laryngitis Cleft lip/palate	Vocal cord polyps Speech delay Bad breath
<u>Cardiovascular:</u>	Chest pain/palpitations	Heart murmur	Swollen ankles
<u>Respiratory:</u>	Chronic cough Shortness of breath	Wheezing Snoring	Sputum increase Sleep apnea/CPAP
<u>Gastrointestinal:</u>	Swallowing difficulty Vomiting	Heartburn GI bleeding	Nausea Change in bowel habits
<u>Genitourinary:</u>	Frequent urination Prostate problems Breast disease	Urine infections Menopause Breast feeding?	Venereal disease Pregnancy problems
<u>Musculoskeletal:</u>	Weakness	Joint pains	Muscle cramps
<u>Skin:</u>	Rashes	Itching	Skin lesions
<u>Neuropsychiatric:</u>	Seizures Anxiety Drug/ETOH addiction	Tremor Depression Increased stress	Headaches Psychiatric care
<u>Endocrine:</u>	Heat/cold intolerance	Increased thirst	
<u>Hematological:</u>	Blood transfusions	Bruise easily	Clotting problems
<u>Allergic/Immunologic:</u>	Seasonal	Food	Receive shots?
<u>Other/Comments:</u>			

Reviewed by _____

ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C.
SHELLEY R. BERSON M.D., F.A.C.S.

2 Strawtown Road
West Nyack, New York 10994
Bardonia, NY 10954
(845) 727-1340
(845) 727-1349 fax

Your Insurance Company

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up to date with each program's provisions.

Some programs require that a specific facility be used for your x-rays, ultrasounds or blood tests.

Some programs "require" referrals for each visit/test.

Some programs require pre-authorization, while others do not.

Some insurance companies require PATIENTS to notify them of hospital admissions or trips to the emergency room.

Some programs require specific information regarding hospitalization.

It is your responsibility to know:

1. Whether this office is participating with your particular plan and program and
2. Whether you have a valid referral for today and future visits/tests.
3. To advise this office of your program's requirements in advance each and every time we provide a service. We will do our best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or use a laboratory that is outside of the program, you will be responsible for the appropriate fees.

In addition, there are times that we may not be able to obtain a consult or laboratory that is participating with our program. It will be up to you to work this out with your insurance company.

These are not our regulations, they are your insurance company's regulations, and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance papers for future reference.

I acknowledge receipt of this information.

Signature

Date

HIPPA ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C. Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Date: _____

Patient's Signature

MEDICARE PATIENTS ONLY

Name of patient

Health Insurance Claim #

I request that payment of authorized Medigap/supplemental benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to:

Name of Medigap Insurance

any information needed to determine these benefits payable for related services.

Patient Signature

Date

ROCKLAND EAR, NOSE AND THROAT ASSOCIATES, P.C.

SHELLEY R. BERSON, M.D., F.A.C.S

2 Strawtown Road
Suite 6-7
West Nyack, NY 10994
(845) 727-1340
Fax: (845) 727-1349

OFFICE CANCELLATION POLICY

PLEASE BE AWARE THAT IF AN APPOINTMENT IS **NOT** CANCELLED AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE CHARGED A FEE OF \$25.00.

THIS FEE IS **NOT** COVERED BY YOUR INSURANCE COMPANY.

THANK YOU FOR YOUR COOPERATION.

Signature_____

Date_____