ENT Associates of Central PA

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Patient Registration Form

Patient Name: _____ Date of Birth: ___/___/___ Age____ Sex: M / F
Preferred Name: _____ Social Security Number: ____-___-____
Address: _____
(Street) (City/State/Zip)
Primary Phone: _____ (Circle one) Cell / Home / Work
Secondary Phone: _____ (Circle one) Cell / Home / Work
Email Address: _____
Employer (If patient is a minor, parent or guardian's employer): _____

Person Responsible for bill or Parent/Legal Guardian: (Complete ***only*** if different from patient)
Relationship to Patient (please ✓): ( )Spouse, ( )Parent, ( )Legal Guardian (Paperwork must be provided)
Guarantor Name: _____ Date of Birth ___/___/___ Sex: M / F
Social Security Number: ____-___-____ Email Address: _____
Information same as above: ☐
Address: _____
(Street) (City/State/Zip)
Primary Phone: _____ (Circle one) Cell / Home / Work

*****IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US, FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER*****

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under the Title VXIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE: I hereby authorize **ENT Associates of Central PA** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issues payment check(s) directly to the physician(s) rendering the covered services.

I authorize ENT Associates of Central PA to furnish complete information to my insurance carrier or its intermediaries regarding services rendered, indefinitely or until revoked by patient.

Initial: _____

Due to HIPAA enactment regarding patient confidentiality issues, we cannot give or discuss information pertaining to your health with anyone other than yourself. If you would like us to be able to discuss your health with someone else (Example: Spouse, Daughter, Son, etc.) please list their name(s) and relationship(s) below:
(This may be revoked at the patient's request with written consent)

_____

_____

Initial: _____

I hereby certify that all of the above information is correct and true and will be reviewed yearly with **ENT Associates of Central PA.** I can revoke or change any of the above information at any time with written consent.

Signature of Patient/ Legal Guardian: _____ **Date:** _____

ENT Associates of Central Pennsylvania

ENT Associates of Central PA, PC

3341 Beale Avenue • Altoona, PA 16601 • Phone (814) 944-5357 • Fax (814) 946-8017

PATIENT FINANCIAL RESPONSIBILITY POLICY AND DISCLOSURE STATEMENT

Your signature below forms a binding agreement between ENT Associates of Central PA, PC (the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (patient under age 18).The Responsible Party is the individual who is financially responsible for payment of all medical bills.

All charges for services rendered are due and payable at the time of service. We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible for all payments if your insurance company declines to pay for any reason.

The Patient and/or the Responsible Party:

- MUST, at each office visit, inform ENT Associates of Central PA, PC (ENTACPA) of the current address and telephone number for both the Patient and the Responsible Party
- MUST present all current insurance cards prior to each office visit
- MUST verify, at each visit, the name of your family physician and all other demographic information
- MUST comply with the payment policy requirements outlined in PATIENT PAYMENT POLICY **(Please see Patient Payment Policy, Effective August 1, 2014)**
- MUST agree to pay a $35.00 fee for checks returned for insufficient funds

NOTE:

It is important to note that patients often require additional testing or surgical procedures including, but not limited to, endoscopy, laryngoscopy, and tubes. As per the *National Correct Coding Initiative*, and our contracts with insurers, we are required to submit a bill for these services **SEPARATE** from the office visit fee. The fees for these procedures are in **ADDITION** to the co-pay for the office visit. The Patient or the Responsible Party is responsible for the payment of these additional fees.

We require a credit card to secure payments for any unknown balance that your insurance company may not cover. Once ENTACPA receives an Explanation of Benefits (EOB) from your insurance, we will charge your credit care if there is any outstanding balance that is owed. **Your signature on this form is your authorization to process payments to the credit card you provided. Balances greater than $300 patient will be charged a minimum payment of $100 per month until paid in full.**

Non-Payment of Account:

All account balances must be paid, in full. **Should collection proceedings become necessary to collect balances on overdue accounts, The Patient will be terminated from the Practice**. ENTACPA has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, all court costs, attorney fees, and collection fees, if assessed to the outstanding balance.

As the Patient or the Responsible Party, your signature indicates that you have read, understand and accept the terms and conditions in the Patient Financial Responsibility Policy and Disclosure Statement.

Print Patient's Name: _____

Patient's Signature: _____ Date_____

Print Responsible Party's Name: _____

Responsible Party's Signature: _____ Date_____

ENT ASSOCIATES OF CENTRAL PA

PATIENT HEALTH HISTORY

Patient Name :_____ Date of Birth: ___/___/___ Height:_____ Weight:_____

Pharmacy (Include Location):_____

Reason for today's visit: _____

Primary Care Physician: _____ Referring Physician: _____

Have you ever been treated with chemo or radiation therapy? ___No ___Yes—When? _____

ARE YOU TAKING ANY **MEDICATIONS** NOW? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DOSAGES ☐ **SEE LIST**

Medication	Dosage	How Often	Medication	Dosage	How Often

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? ___NO ___YES PLEASE LIST BELOW AND INCLUDE REACTION ☐ **SEE LIST**

Medication Name	Reaction	Medication Name	Reaction

HAVE YOU HAD ANY **SURGERIES**? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DATES ☐ **SEE LIST**

Type of Surgery	Date	Type of Surgery	Date

HAVE YOU BEEN **HOSPITALIZED** FOR NON SURGICAL REASONS? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DATES ☐ **SEE LIST**

Reason Hospitalized	Date	Reason Hospitalized	Date

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: (Please check all that apply)

Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐

Diabetes ☐ Stroke ☐ Pneumonia ☐

Problems with Anesthesia ☐ Please Explain: _____

Bleeding/ Clotting Problems ☐ Please Explain: _____

Other: _____

_____ _____

SIGNATURE OF PATIENT/ LEGAL GUARDIAN DATE

Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.
- Fill in date on the line when MM/YR is present.

Correct Mark ● Incorrect Marks ◐ ✓ ✗

3 6 - 2 1 6 8 4 8 2

DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Race *(Mark Only One)*

- American Indian or Alaskan Native ○
- Asian ○
- Black or African American ○
- Decline to State ○
- Native Hawaiian or Other Pacific Islander ○
- Some Other Race ○
- White ○

2. Ethnicity *(Mark Only One)*

- Decline to State ○
- Hispanic or Latino ○
- Not Hispanic or Latino ○

3. Preferred Language *(Mark Only One)*

- English ○
- Spanish ○

4. Preferred method of receiving office reminders *(Mark Only One)*

- Opt Out ○
- Home Phone ○
- Work Phone ○
- Mobile Phone ○
- Other Phone ○
- Home Fax ○
- Work Fax ○
- Mail ○
- Patient Portal ○

5. Food Allergies or Intolerances

	Yes		Yes
Eggs	○	Yeast – Baker's	○

6. Cancers

	Date Diagnosed	Yes
Bladder	MM / YR	○
Bone	MM / YR	○
Brain	MM / YR	○
Breast	MM / YR	○
Cervical	MM / YR	○
Colon	MM / YR	○
Esophagus	MM / YR	○
Ewing's Sarcoma	MM / YR	○
Hodgkin's Disease	MM / YR	○
Kaposi Sarcoma	MM / YR	○
Kidney	MM / YR	○
Larynx	MM / YR	○
Leukemia	MM / YR	○
Liver	MM / YR	○
Lung	MM / YR	○
Lymphoma	MM / YR	○
Multiple Myeloma	MM / YR	○
Ovarian	MM / YR	○
Pancreas	MM / YR	○
Pheochromocytoma	MM / YR	○
Polycythemia Vera	MM / YR	○
Prostate	MM / YR	○
Rectum	MM / YR	○
Skin – Basal Cell	MM / YR	○

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6. Cancers *(continued)*

	Date Diagnosed	Yes
Skin – Malignant Melanoma	MM / YR	○
Skin – Squamous Cell	MM / YR	○
Skin – Unknown Type	MM / YR	○
Stomach	MM / YR	○
Testicular	MM / YR	○
Throat	MM / YR	○
Thyroid	MM / YR	○
Uterine	MM / YR	○

7. Past Health History

	Date Diagnosed	Yes
High Blood Pressure (Hypertension)		○
Pregnant – Pregnancy Has Been Confirmed		○
Encephalopathy		○
Neuralgia	MM / YR	○
Neuritis	MM / YR	○
Paralysis	MM / YR	○
Progressive Neurologic Disorder		○
Radiculitis	MM / YR	○
Intravenous Drug Abuse	MM / YR	○
Autoimmune Disorder		○
HIV Positive (Asymptomatic)		○

8. Past Surgeries

	Procedure Date	Yes
Colectomy – Total		○
Colonoscopy	MM / YR	○
Hysterectomy		○
Mastectomy – Details Unspecified		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Modified Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Simple		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○

EXAMPLE TO FILL IN DATES

If you have had paralysis in December of 1990, fill in the oval and write the date as shown below.

Paralysis 12/90 ●

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9. Mark any back injuries you have had:

	Injury Date	Yes
Thoracic injury of the back		○
Lumbar injury of the back		○
Ruptured disc – L1-2		○
Ruptured disc – L2-3		○
Ruptured disc – L3-4		○
Ruptured disc – L4-5		○
Ruptured disc – L5-S1		○
Ruptured disc – S1-2		○
Ruptured disc – Specific location unknown		○
Wound (gun shot) to back		○
Wound (stab wound) to back		○
Vertebral fracture – Lumbar		○
Vertebral fracture – Thoracic		○
Vertebral fracture – Location unspecified		○

10. Immunizations Immunization Date

Diptheria – Tetanus – Pertussis (DTP)

MARK EITHER:		Yes
Completed series	MM / YR	○
OR		
#4 of series	MM / YR	○
#5 of series	MM / YR	○

Haemophilus Influenza Type B Conjugate Vaccine (HIB)

MARK EITHER:		Yes
Had series in past		○
OR		
#2 of series		○
#3 of series		○
Booster		○

Hepatitis A (HAV)

		Yes
#2 of series	MM / YR	○
Booster	MM / YR	○

Hepatitis B Vaccine (HBV)

MARK EITHER:		Yes
Had the series		○
OR		
#3 of series		○
#4 of series		○
Repeat series was administered		○
Booster		○

Influenza Vaccine

		Yes
Never received this vaccine		○
Has received this vaccine	MM / YR	○
Declined vaccine		○

Measles – Mumps – Rubella (MMR)

MARK EITHER:		Yes
Completed the series		○
OR		
First or only MMR vaccination		○
Second MMR vaccination		○

10. Immunizations *(continued)* Immunization Date

Pneumococcal Conjugate Vaccine (PCV)
(Pneumonia vaccine given as a child)

		Yes
Booster	MM / YR	○

Pneumococcal Polysaccharide Vaccine (PPV)
(Pneumonia vaccine given as an adult)

		Yes
Primary PPV immunization		○
Revaccination		○

Polio – Inactivated Polio Virus (IPV)

MARK EITHER:		Yes
Completed the series	MM / YR	○
OR		
#3 of series	MM / YR	○
#4 of series	MM / YR	○

Rotavirus Vaccine

MARK EITHER:		Yes
Has received 2 or more doses		○
OR		
#2 of series		○
#3 of series		○

Varicella (VZV)

MARK EITHER:		Yes
Has received 1 or more doses	MM / YR	○
OR		
#1 or only immunization	MM / YR	○
#2	MM / YR	○

11. Most Recent Diagnostic/Screening Tests

	Test Date	Yes
Colonoscopy		○
Fecal Occult Blood Testing (FOBT)		○
Sigmoidoscopy – Flexible		○
Pap Smear		○
Mammography		○

12. Current Smoking Status

(Mark one of the following)	Yes
Never smoked	○
Former smoker	○
Current every day smoker	○
Current some day smoker	○

13. Use of tobacco products in the past that are no longer used.
(Mark if applicable) ○

Patient Health History

DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ■ Incorrect Marks ◐ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	☐	Metal	☐
Iodine	☐	Seafood	☐
Latex	☐	Contrast Dye	☐

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	☐	Gastrointestinal Reflux	☐
Lung Cancer	☐	Hepatitis	☐
Skin Cancer	☐	Stomach Ulcer	☐
Throat Cancer	☐		
Prostate Cancer	☐		
Other Cancer	☐	Are you pregnant?	☐
		Prostate Enlargement	☐
Migraine Headache	☐	Renal Failure	☐
Cataracts	☐	Stroke	☐
Glaucoma	☐		
		Anxiety	☐
Nasal Allergies	☐	Depression	☐
Sleep Apnea	☐	Diabetes	☐
		Thyroid Dysfunction	☐
Blood Clots/DVT	☐		
High/Elevated Cholesterol	☐	Anemia	☐
		Hemophilia	☐
Heart Attack	☐		
High Blood Pressure	☐	HIV	☐
Asthma	☐		
Chronic Bronchitis	☐		
Emphysema	☐		
Tuberculosis	☐		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Unspecified Cancer	☐	☐	☐	☐	☐
Hearing Loss before age 20	☐	☐	☐	☐	☐
Hearing Loss after age 20	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐	☐

4. Mark if retired. Yes ☐

5. Tobacco Use:
Mark your tobacco use.

☐ None ☐ Cigarettes
☐ Smokeless Tobacco ☐ Cigars

Give the closest amount of cigarettes you smoke in an average day.

☐ 1/2 pack ☐ 2 packs
☐ 1 pack ☐ 3 packs
☐ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

☐ Less than 12 drinks/yr
☐ 1-13 drinks/mo
☐ 4-14 drinks/wk
☐ >2 drinks/day

6. Do you use drugs recreationally? Yes ☐

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

☐ None ☐ 2-3 per day
☐ 1 per day ☐ 4 or more

8. Are you exposed to second hand smoke? Yes ☐

9. Mark if patient attends daycare. Yes ☐

10. Will you accept transfusion of blood products if necessary? Yes ☐

11. Home Living Situation (mark all that apply).

☐ Alone ☐ With spouse
☐ With children ☐ In nursing home
☐ With mother ☐ With father
☐ In assisted living ☐ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	☐
Sleeping problems	☐
Unintentional weight loss	☐
Unintentional weight gain	☐
Blurred vision	☐
Itchy eyes	☐
Loss of vision	☐
Painful eye	☐
Dizziness	☐
Ear drainage	☐
Hearing loss	☐
Ear pain	☐
Ringing in the ears	☐
Nasal congestion	☐
Frequent nosebleeds	☐
Post-nasal drainage	☐
Belching sour material into throat	☐
Hoarseness or other voice changes	☐
Mouth ulcers	☐
Partials or dentures	☐
Blacking out or fainting	☐
Chest pain	☐
Heart murmur	☐
Irregular heartbeats	☐
Leg cramps	☐
Swelling of ankles	☐
Frequent non-productive cough	☐
Frequent productive cough	☐
Shortness of breath	☐
Snoring (excessive)	☐
Wheezing	☐
Abdominal pain	☐
Diarrhea	☐
Heartburn	☐
Nausea	☐
Trouble swallowing	☐
Painful swallowing	☐
Vomiting	☐
Painful joints	☐
Stiffness in joints	☐
Swelling of joints	☐

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	☐
Change in sense of taste	☐
Headache	☐
Severe face pain	☐
Seizures	☐
Tremor	☐
Appetite is increased	☐
Fatigue	☐
Cold feeling	☐
Bleed excessively after injury	☐
Bruise easily	☐
Masses (lumps) in armpit	☐
Masses (lumps) in neck	☐
Masses (lumps) in groin	☐
Hives	☐
Sneezing	☐