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

REGISTRATION INFORMATION

PATIENT'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

CURRENTLY WORKING? YES NO PATIENT'S CURRENT EMPLOYER & PHONE NUMBER

EMPLOYERS ADDRESS CITY STATE ZIP CODE

EMAIL ADDRESS (USED TO CREATE YOUR PATIENT PORTAL)

RESPONSIBLE PARTY IF OTHER THAN PATIENT – RELATIONSHIP	EMPLOYER OF RESPONSIBLE PARTY

MAILING ADDRESS OF RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE) CITY STATE ZIP CODE

PATIENT'S PRIMARY INSURANCE	RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)
POLICY HOLDER'S NAME	POLICYHOLDER'S DOB AND SS#
PATIENT'S SECONDARY INSURANCE (IF APPLICABLE)	RELATIONSHIP TO PATIENT (SELF / SPOUSE / PARENT/ OTHER)
POLICY HOLDER'S NAME	POLICYHOLDER'S DOB AND SS#

IN CASE OF AN EMERGENCY, NOTIFY:

NAME PHONE RELATIONSHIP

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 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. I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES and I am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice. I understand that I may request, in writing, restrictions to the use or disclosure of my protected health records, and that I am able to provide access to my personal health information by written authorization.

_____

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):

_____

_____

_____

_____

MEDICATIONS ALLERGIES: YES NONE (UNKNOWN)

_____

_____

_____

ENVIRONMENTAL/SEASONAL ALLERGIES
(INCLUDING LATEX, CONTACT ALLERGIES): YES NONE (UNKNOWN)

_____

_____

_____

FOOD ALLERGIES: YES NONE (UNKNOWN)

_____

_____

_____

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

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
CANCER	☐	☐	☐	☐	_____
ASTHMA	☐	☐	☐	☐	_____
LUNG DISEASE/ COPD	☐	☐	☐	☐	_____
DIABETES	☐	☐	☐	☐	_____
HEART ATTACK	☐	☐	☐	☐	_____
HEART DISEASE	☐	☐	☐	☐	_____
HEART MURMUR	☐	☐	☐	☐	_____
HIGH BLOOD PRESSURE	☐	☐	☐	☐	_____
RINGING IN THE EARS	☐	☐	☐	☐	_____
HEARING LOSS	☐	☐	☐	☐	_____
THYROID PROBLEMS	☐	☐	☐	☐	_____
WEIGHT LOSS	☐	☐	☐	☐	_____
ARTHRITIS	☐	☐	☐	☐	_____
DIZZINESS	☐	☐	☐	☐	_____
MIGRAINES	☐	☐	☐	☐	_____

	YOURSELF		FAMILY		
	YES	NO	YES	NO	RELATION
KIDNEY PROBLEMS	☐	☐	☐	☐	_____
FEVERS	☐	☐	☐	☐	_____
PROSTATE OBSTRUCTION	☐	☐	☐	☐	_____
STROKE	☐	☐	☐	☐	_____
TUBERCULOSIS	☐	☐	☐	☐	_____
POLIO	☐	☐	☐	☐	_____
GLAUCOMA	☐	☐	☐	☐	_____
NERVE OR PSYCHIATRIC DISEASE	☐	☐	☐	☐	_____
UNUSUAL CHILDHOOD DISEASE	☐	☐	☐	☐	_____
STOMACH ULCERS/ HEART BURN	☐	☐	☐	☐	_____
NECK PROBLEMS	☐	☐	☐	☐	_____
BLEEDING PROBLEMS	☐	☐	☐	☐	_____
HPV	☐	☐	☐	☐	_____
HIV VIRUS	☐	☐	☐	☐	_____
HEPATITIS type: _____	☐	☐	☐	☐	_____

OTHER PHYSICAL RESTRICTIONS: _____

_____

ALL SURGERIES, INCLUDING THE YEAR: _____

_____

_____

_____

IMMUNIZATIONS: UP TO DATE? ☐ YES ☐ NO IMMUNIZATIONS FOR: ☐ FLU ☐ SHIINGLES ☐ PNEUMONIA YEAR: _____

DO YOU USE TOBACCO?
☐ CURRENT ☐ FORMER ☐ NEVER

DO YOU USE ALCOHOL?
☐ CURRENT ☐ FORMER ☐ NEVER

DO YOU USE ASPIRIN?
☐ DAILY ☐ SOMETIMES ☐ NEVER

RECREATIONAL DRUGS?
☐ CURRENT ☐ FORMER ☐ NEVER

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** (12-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:** _____

Ear, Nose and Throat Associates of Northern Colorado & The Hearing and Balance Clinic

Affiliated with Ear, Nose and Throat Associates of Northern Colorado

INTAKE QUESTIONNAIRE

Thank you for visiting us today. To help us provide you with the best possible care, please take a few moments to complete the following questionnaire. Your responses will help make your hearing evaluation and fitting appointment more efficient, effective and successful.

INSTRUCTIONS

- Please read the following statements
- Beside each statement, mark the question mark that ***best*** describes your experience in each situation

Name: _____ **Date:** _____

	Always	Sometimes	Never
1. I have to ask people to repeat themselves even when I am in a quiet conversation with one or two people.	?	?	?
2. My family members complain that I need to turn the television volume louder than they do.	?	?	?
3. When I talk on the phone or cell phone, I miss some of what is being said.	?	?	?
4. During a card game or any other game around a table I have difficulty hearing the conversation.	?	?	?
5. When I am in a busy public place, such as a shopping center, I have difficulty communicating with others.	?	?	?
6. In meetings, I have to strain to make sure I hear everything.	?	?	?
7. When I am eating in a restaurant, I have to ask my dining companion to repeat things.	?	?	?
8. I miss a lot of information during church and/or classroom lectures.	?	?	?
9. When I am listening to music/concerts, I miss parts of the performance.	?	?	?
10. If I am in the car with others who are talking, I cannot hear what they are saying.	?	?	?

Circle the top 3 listings, situations/environments in which you experience the most difficulty hearing and would like to experience an improvement. (If not outlined above, list below).

_____

_____

2121 E Harmony Rd. Ste 350 Ft. Collins, CO 80528
Phone (970) 484-6373 Fax (970) 484-0382