Advanced ENT & Allergy — Penn Medicine Ear, Nose and Throat | Affiliate

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ County: _____

Race: _____ Primary Language: _____ Ethnicity: ☐ Hisp./Latino ☐ Non-Hisp./Latino ☐ Declined

Name & Address of Primary Care (family) Physician/Pediatrician: _____

_____

Referring Physician Name (if different): _____

Preferred Pharmacy: _____ In What City?: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Student Status: ☐ PT ☐ FT

Home Phone: _____ Work Phone: _____ Cellphone: _____

Email Address: _____

You may receive health education emails from Advanced ENT & Allergy. If you would like to discontinue receiving these emails, you will have the option to select unsubscribe in the email.

Employer: _____ Employer Address: _____

What is (or was) your occupation? _____ Retired? ☐ Yes ☐ No

Name and relationship of person who has your authorization to accompany the patient to visit (minor) or receive medical information on your behalf—Name: _____ Relationship: _____

DOB: _____ (required) Address: _____ Phone: _____

PRIMARY MEDICAL INSURANCE

Policy Holder Name: _____ SSN: _____ DOB: _____

Plan Name: _____ Policy Holder #: _____ Patient Policy #: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Ins. Co. Address: _____ Phone: _____

SECONDARY MEDICAL INSURANCE

Policy Holder Name: _____ SSN: _____ DOB: _____

Plan Name: _____ Policy Holder #: _____ Patient Policy #: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Ins. Co. Address: _____ Phone: _____

Is this visit covered by Workers' Comp? ☐ Yes ☐ No **No Fault?** ☐ Yes ☐ No

Emergency Contact: _____ **Phone:** _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

I have received the Advanced ENT & Allergy notice of privacy practice and the Advanced ENT & Allergy financial policy.

Responsible Party Signature: _____ **Date:** _____

Please be prepared to make payment for your copay, outstanding balance or services not covered by medical insurance at the time of your appointment. If you are unable to attend your scheduled appointments, we ask that you provide at least 24 hours' notice to avoid a $25 fee. A $25 service charge will be added to any returned check. We thank you for your cooperation.

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Last Name: _____ First Name: _____ Middle Initial: _____

Date Today: _____ Birth Date: _____ Primary Doctor: _____ Referring Doctor: _____

Chief Problem(s): _____

PAST MEDICAL HISTORY

ENT: ☐ Ear Infections ☐ Sinus Infections ☐ Allergies ☐ Throat Problems ☐ Voice Problems

Eyes: ☐ Glaucoma ☐ Cataracts

Heart: ☐ Heart Attack ☐ Irregular Heartbeat ☐ Abnormal Heart Valve ☐ High Blood Pressure

Lung: ☐ Asthma ☐ COPD ☐ Tuberculosis ☐ Emphysema ☐ Sleep Apnea

Gastrointestinal: ☐ Reflux ☐ Stomach Problems ☐ Hepatitis ☐ Cirrhosis ☐ Hiatal Hernia

Kidney: ☐ Kidney Failure ☐ Incontinence ☐ Prostate Problems ☐ Bladder Problems

Neurologic: ☐ Stroke ☐ Headaches ☐ Seizures ☐ Multiple Sclerosis

Psychiatric: ☐ Depression ☐ Anxiety

Endocrine: ☐ Diabetes ☐ Thyroid Problems

Hematologic: ☐ Anemia ☐ Bleeding Disorder

Rheumatologic: ☐ Arthritis ☐ Fibromyalgia ☐ Autoimmune Disorder ☐ Osteoporosis

Dermatologic: ☐ Keloids ☐ Skin Conditions

Infectious: ☐ HIV ☐ Lyme Disease ☐ Mononucleosis

Oncologic: ☐ Cancer List Sites: _____

Other: _____

PAST SURGICAL HISTORY

ENT: ☐ Tonsillectomy/ Adenoidectomy ☐ Ear Surgery ☐ Nose/Sinus Surgery ☐ Tracheotomy

Heart: ☐ Bypass Stent ☐ Valve Surgery ☐ Carotid Artery ☐ Pacemaker ☐ Other

Lung: ☐ Bronchoscopy ☐ Lung Surgery

GI: ☐ Surgery for Reflux ☐ Stomach Surgery ☐ Intestinal Surgery ☐ Gallbladder

Orthopedic: ☐ Fracture ☐ Knee Replacement ☐ Hip Replacement ☐ Back Surgery

Pelvic: ☐ Prostate ☐ Bladder ☐ D&C ☐ Gyn Surgery ☐ Kidney Surgery

Other: ☐ Breast ☐ Neurosurgery ☐ Dental ☐ Eye

MEDICATIONS

Please list all medications (or provide list on separate paper). Please include over-the-counter medications.

MEDICATION	DOSE	REASON	MEDICATION	DOSE	REASON

PLEASE TURN PAGE OVER

ALLERGIES

Please list all allergies to medications and foods: ☐ No Allergies

ALLERGY	REACTION

FAMILY HISTORY

Check if any of these run in the family (only those related by blood):

☐ Autoimmune Disease ☐ Bleeding/Coagulation Disorder ☐ Heart Disease

☐ Diabetes ☐ Thyroid Disease ☐ Hearing Loss

☐ High Blood Pressure ☐ Tuberculosis ☐ Problems with Anesthesia

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Other

Occupation: Current: _____

Prior: _____

Noise Exposure: ☐ At Work ☐ In Military ☐ Noise from Hobbies

Tobacco:

☐ Never Smoked

☐ Current Smoker: Amount: _____ per day # of years smoking: _____

☐ Former Smoker: Stopped: _____

Alcohol:

☐ Never Drank Alcohol

☐ Drink Currently: ☐ Beer ☐ Wine ☐ Liquor amount per day _____

☐ Former Drinker: Stopped: _____

Caffeine:

☐ Coffee oz./ day: _____

☐ Tea oz./day: _____

☐ Caffeinated Soft Drinks oz./day: _____

SPECIAL CONCERNS

☐ Pregnant (due: _____) ☐ Breastfeeding ☐ Taking Blood Thinners

☐ Require Antibiotics for Procedures ☐ Latex Allergy

REVIEW OF SYSTEMS

Please check other active symptoms:

Gen: ☐ Fatigue ☐ Fever Chills ☐ Night Sweats ☐ Weight Loss ☐ Weigh Gain ☐ Loss of Appetite

Eyes: ☐ Itchy Eyes ☐ Eye Discomfort ☐ Double Vision ☐ Blurred Vision ☐ Change in Vision Dry Eyes

CV: ☐ Chest Pain ☐ Irregular Heartbeats ☐ Rapid Heartbeat ☐ Lightheadedness

Resp: ☐ Shortness of Breath ☐ Wheezing Cough ☐ Sputum Production ☐ Coughing Up Blood

GI: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Difficulty Swallowing ☐ Heartburn ☐ Reflux
☐ Vomiting ☐ Blood Belching ☐ Abdominal Pain

GU: ☐ Problems Passing Urine ☐ Incontinence ☐ Possible Pregnancy

Derm: ☐ Rash ☐ Itchiness ☐ Pigmentation Changes ☐ Dry Skin

Neuro: ☐ Change in Mental Status ☐ Muscle Weakness ☐ Loss of Coordination ☐ Tingling or Numbness
☐ Change in Speech ☐ Seizures ☐ Tremors ☐ Loss of Balance ☐ Developmental Delay

Rheum: ☐ Joint Pain

Endoc: ☐ Cold Intolerance ☐ Heat Intolerance

Psych: ☐ Anxiety Depression ☐ Behavior Problems

Hem: ☐ Easy Bleeding ☐ Easy Bruising

Allergy: ☐ Allergic Dermatitis

FINANCIAL POLICY

Our objective is to provide you with the highest quality health care in the most cost-effective manner. However, the ability of our Practice to achieve this objective depends greatly on your understanding of our Financial Policy. If you have medical insurance, we will file insurance claims forms on your behalf. We do this as a courtesy to our patients and are anxious to help you receive the maximum allowable benefits from your insurer. Even though we will file insurance claims for you, we need your active participation in the insurance claims process.

MEDICARE PATIENTS:

As a participating provider of Medicare Part B (physician services), our Practice will only bill for your Medicare co-insurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. **NOTE:** You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services. *If you have Medicare Part A only, then the services that you receive from our Practice will not be covered by Medicare.*

COMMERCIAL INSURANCE PATIENTS:

Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. If your claim remains unpaid by your carrier for more than 90 days from the date of service provided, the balance will become your responsibility.

NONPARTICIPATING PLAN PATIENTS:

As the insurance industry changes, our office must make choices about which plans to participate in. Your plan may be one that covers certain areas with "out of network" benefits. These are usually Preferred Provider Organizations (PPO), Point of Service (POS) or indemnity plans that cover percentages of our fees based on the contract with your carrier. In some instances, your carrier will send a check directly to you (the patient) or the account guarantor rather than the provider's office. Due to this, we offer several options for you to ensure that your services are paid timely. 1) You may elect to pay your balance at or before the services are rendered and receive a 30% prompt-pay discount. 2) If you prefer that we bill your insurance carrier, the full charge will have 30 days to be satisfied, with no discount, either from the check you receive from the insurance carrier or your own funds. If your balance is not paid within 30 days of services being rendered, your account may incur additional collection fees to satisfy the account balance.

HMO/MANAGED CARE INSURANCE PATIENTS:

Many HMO/Managed Care plans require you to obtain a referral in order to see a specialist. It is your responsibility to obtain this referral if required. Unauthorized services will be the financial responsibility of the patient. Please have your referral forms and membership card available when you check in. You will be required to pay the co-pay for authorized services at the time of service. **A $15 service fee will be assessed to your account if the co-pay is not received at the time of service.** We will make every attempt to collect for our services with your insurance company; however, if your claim remains unpaid over 90 days from the date of services were rendered, the payment will become your responsibility.

PATIENTS WITH NO INSURANCE:

Patients with no insurance are required to pay for their visits at the time of service. If special financial arrangements are deemed necessary, you will be given information regarding whom to contact at the time of your visit. It is imperative you follow those instructions immediately to satisfy your financial responsibility for services provided to you.

I agree to allow this health care provider to file an appeal on my behalf with my health plan for any services provided by Regional Otolaryngology Head & Neck Assoc., LLC DBA Advanced ENT & Allergy.

SIGNATURE: _____ DATE: _____

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CULTURAL COMPETENCY

The State of New Jersey mandates every physician documents any barrier to care, including cultural and linguistic needs, in the medical record. Factors affecting care are visual and auditory factors, which may impede your ability to comprehend medical discussion, and language, cultural and religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decrease health care disparities.

Patient Name: _____ Date of Birth: _____

1. Do you have any impairment? (Please check any that apply)
   - ☐ Visual
   - ☐ Hearing
   - ☐ Speech
   - ☐ Learning
   - ☐ Physical
   - ☐ Language/Cultural Barrier
   - ☐ None

2. What language do you speak, read and write?: _____

_____

3. Do you have any religious or cultural customs that the doctor should know about? (If you choose yes, please explain)
   - ☐ Yes, please explain: _____
   - ☐ No: _____

4. ADVANCE DIRECTIVES: FOR ALL PATIENTS 18 YEARS AND OLDER: Advanced Directive is a federal- and state-mandated Self-Determination Act enacted in 1990. This act allows you to provide specific instruction and direction regarding your own medical care wishes if you become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions.

   Do you have a "Living Will" or Advanced Directive? (Please circle)

   ☐ Yes

   ☐ No

_____ _____

Signature Date

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Patient Name: _____ Date of Birth: _____

AFFILIATION NOTICE
PATIENT DISCLAIMER & ACKNOWLEDGEMENT

Advanced ENT & Allergy is pleased to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Advanced ENT & Allergy is working with Penn Medicine to improve the quality of care provided to its patients.

Advanced ENT & Allergy is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by Advanced ENT & Allergy. Each physician affiliated with Advanced ENT & Allergy exercises independent medical judgement in the care of his or her patients. If you have any questions about the relationship that Advanced ENT & Allergy has with Penn Medicine, please ask your physician.

SIGNATURE: _____ DATE: _____

PROCEDURE NOTICE

Please know that some commonly performed procedures of your ENT examination in this office may not be covered by your insurance carrier.

These may include FIBEROPTIC EXAMINATIONS of the nose and larynx/vocal cords. If such a procedure is performed, a procedural fee will be submitted to your insurance carrier. You should know that your insurance carrier may refer to these routine parts of your specialist's consultation as PROCEDURES or even SURGICAL PROCEDURES. If our office participates with your insurance carrier, you will only be obligated to pay for any deductibles, co-insurance and co-pays as agreed upon by you and your carrier. Please know that the performance of these procedures by your specialist is to give you the most accurate and best care available.

SIGNATURE: _____ DATE: _____