



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

SSN: _____ DOB: _____ Birth Sex: Male Female Marital Status: _____

Gender Identity: Identifies as Male Identifies as Female Transgender Male/Trans Man (FTM) Transgender Female/Trans Woman (MTF) Genderqueer (Neither exclusively Male Nor Female) Other Choose Not to Disclose

Preferred Pronoun: He, Him, His She, Her, Hers They, Them, Their

Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____ Apt. #: _____

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

Home Phone: _____ Work Phone: _____ Cellphone: _____

Email Address: _____ Preferred Contact Method: Phone Text Email

Do you want to receive marketing emails? Yes No How did you hear about us? _____

Emergency Contact Name: _____ Phone: _____

Name and relationship of the person who has your authorization to receive medical information on your behalf:

Name: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Referring Provider (if different): _____

Employer: _____ Occupation: _____

Preferred Pharmacy: _____ In What City? _____

Do we have your consent for Advanced ENT & Allergy to pull your medication history from your pharmacy? Yes No

PRIMARY MEDICAL INSURANCE:

Insurance Name: _____ Insurance ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Group Name: _____ Group Number: _____

SECONDARY MEDICAL INSURANCE:

Insurance Name: _____ Insurance ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Group Name: _____ Group Number: _____

Is this visit covered by workers' comp? Yes No

No-fault insurance? Yes No

FINANCIAL RESPONSIBILITY FOR MINORS:

Financially Responsible Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Address: _____

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 confirm I have reviewed the Advanced ENT & Allergy notice of privacy practice.

Signature: _____ Date: _____



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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES

Please list all allergies to medications and foods: No Allergies

ALLERGY**REACTION**

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

ADVANCED ENT & ALLERGY - 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 eager 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.

Please be prepared to make payment for your co-pay, 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–\$50 fee. A \$25 service charge will be added to any returned check. We thank you for your cooperation.

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 only have Medicare Part A, then the services 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 will 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 organization (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 promptly. 1.) You may elect to pay your balance at or before the services 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 to see a specialist. It is your responsibility to obtain this referral if required. Unauthorized services will be the patient’s financial responsibility. 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 your service. **A \$15 service fee will be assessed to your account if a 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 for 90 days from the date the 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 these instructions immediately to satisfy your financial responsibility for services provided to you.

I authorize payment of medical benefits to Advanced ENT & Allergy physicians or their designee for services rendered. I agree to allow this health care provider to file an appeal on my behalf with my health plan.

SIGNATURE: _____ DATE: _____

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



Patient Name: _____ Date of Birth: _____

Exhibit E

Affiliation Notice

The following notice must be provided to and acknowledged by all patients seen at each Practice Site:

PATIENT DISCLAIMER AND 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 Hospital 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.

Please sign below to indicate that you have read this acknowledgement and have had an opportunity to ask questions.

Patient Signature

Date



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

Patient Name: _____ Date of Birth: _____

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.

Patient Signature

Date