THE CENTERS FOR ADVANCED ENT CARE

Chesapeake Otolaryngology Division

# Patient Registration

Registration Date: _____

Patient Name: _____ ☐ Male ☐ Female Parent/Guardian Name: _____
Last Name First Name M.I.

Maiden Name: _____ Social Security #: _____ Email _____

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married

Home Address: _____
Street or P.O. Box City State County Zip Code

Mailing Address: ***(if different than above)*** _____
Street or P.O. Box City State County Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact/Appointment Reminder Preference: ☐ phone ☐ text ☐ email

1st Emergency Contact: _____ Phone #: _____ Relation to Patient: _____
name

2nd Emergency Contact: _____ Phone #: _____ Relation to Patient: _____
name

## INSURANCE POLICY HOLDER FOR PRIMARY INSURANCE *(Complete if different than patient)*

Name: _____ Relation to Patient: _____
Last Name First Name M.I.

Social Security #: _____ Date of Birth: _____ Phone Number: _____

Home Address: _____
Street or P.O. Box City State County Zip Code

Mailing Address: (*if different than above*) _____
Street or P.O. Box City State County Zip Code

## INSURANCE POLICY HOLDER'S Employer

Employer: _____ Work Phone: _____

Address: _____
Street or P.O. Box City State County Zip Code

## INSURANCE INFORMATION

**[Indicate which insurance is PRIMARY, SECONDARY or TERTIARY and complete items in bold print below.]**

**Primary Insurance**
**Insurance Name:** _____
Policy #: _____
Group #: _____
**Policy Holder's Name and DOB: (required)**
_____
Insurance Address: _____
_____

**Secondary Insurance**
**Insurance Name:** _____
Policy #: _____
Group #: _____
**Policy Holder's Name and DOB: (required)**
_____
Insurance Address: _____
_____

**Tertiary Insurance:**
**Insurance Name:** _____
Policy #: _____
Group #: _____
**Policy Holder's Name and DOB: (required)**
_____
Insurance Address: _____
_____

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# PATIENT HISTORY

**PATIENT NAME:** _____ **DATE:** _____
Last Name First Name M.I.

## REASON FOR TODAY'S VISIT: _____

Have you had any labwork, radiology scans, or sleep studies in the last 6 mths? When_____Where_____

## REFERRAL INFORMATION

How did you hear about us? ☐ Doctor ☐ Family Member/Friend ☐ Newspaper/Yellow Pages

☐ Website www.coaent.com ☐ other website _____ ☐ Other_____

Referring doctor's name: _____

Primary care doctor's name: _____

Please list any other doctor that you would like to have notes sent to _____

Pharmacy Name: _____ Phone #: _____ Address: _____

## MEDICAL/SURGICAL HISTORY

Please circle if you have, or have you ever had, any of the following:

| | | |
|---|---|---|
| High Blood Pressure | Obstructive Sleep Apnea | Rheumatoid Arthritis |
| Diabetes | TMJ Syndrome | Multiple Sclerosis |
| Heart Attack/Stent | Stomach Ulcers/Gastritis | HIV or other Immunodeficiency |
| Stroke | Kidney Problems | Cancer |
| Seizures | Liver Problems | Environmental Allergies |
| Thyroid Problems | Hepatitis | Food Allergies |
| COPD | Lupus Erythematosis | Other _____ |
| Asthma | Sarcoidosis | _____ |

If you circled any of the above please specify :

_____

_____

Please list any medications to which you are allergic and the type of reaction _____

_____

Please list any medications you are currently taking (include herbal and OTC products) _____

_____

_____

_____

Please list all operations you have had _____

_____

_____

Pregnant? ☐ Yes ☐ No date of expectancy _____ Do you drink alcohol? ☐ Yes ☐ No how much? _____

Do you or have you ever used tobacco? ☐ Yes ☐ No ☐ cigarettes ☐ cigars ☐ chewing tobacco ☐ Other

If yes, how much, how often, and for how long? _____

When and how did you quit? _____

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**Chesapeake Otolaryngology Division**

Patient Name_____ Date_____
Last Name First Name M.I.

Please circle if you are experiencing or have experienced any of the following in recent months

**Constitutional**
Decreased Appetite
Fatigue
Fever
Night Sweats
Weight Gain/Loss

**HEENT**
Headaches
Eye Itching
Vision Changes

Hearing Loss
Noise Exposure
Ringing/ Noise in Ear

Nasal Discharge
Nosebleeds
Nasal Congestion
Sneezing

Voice Change
Difficulty Swallowing
Lump in Throat
Post Nasal Drip
Sore Tongue/ Throat
Snoring

**Respiratory/ Cardiovascular**
Cough
Shortness of Breath
Wheezing
Chest Pain

**Gastrointestinal**
Abdominal Pain
Constipation
Diarrhea
Heartburn
Acid Reflux
Vomiting

**Metabolic/Endocrine**
Cold/Heat Intolerance
Frequent Thirst/ Hunger
Frequent Urination

**Neuro/ Psychiatric**
Dizziness/ Lightheadedness
Fainting
Difficulty with Speech
Memory Loss
Tremors
Anxiety
Depression
Irritability
Mood Swings

**Dermatological**
Skin Itching (Pruritis)
Skin Rash

**Musculoskeletal/ Hematology**
Joint/ Bone Pain
Easy Bruising
Easy Bleeding

**Immunological**
Environmental/ Seasonal Allergies
Food Allergies

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# Release of Information and Assignment

I hereby authorize you to release to my referring physician and/or family doctor any information including the diagnosis and records of any treatment or examination rendered to me.

I certify that the information I have reported with regard to my insurance coverage is correct. I hereby assign my insurance benefits to be paid directly to Chesapeake Otolaryngology Associates, LLC for services rendered. I acknowledge that I am financially responsible for all non-covered services, deductibles, and copayments. I also authorize Chesapeake Otolaryngology Associates, LLC to release any information required to process this claim.

This authorization may be revoked by either my insurance carrier or me at any time in writing. I understand that my insurance coverage is a contract between the insurance company and myself and that Chesapeake Otolaryngology Associates, LLC will submit claims on my behalf, but will not be responsible for filing appeals or disputing rejections. I authorize and understand that the physician's office will be billing electronically. A copy of this authorization may be used in place of the original.

**I understand that I am responsible for all charges incurred regardless of my insurance status. Charges not paid within ninety (90) days by insurance companies will be made patient responsible. I further agree, in the event of default due to nonpayment, to be responsible for collection fees, court costs and/or legal fees and that there will be a $35.00 fee for all returned checks. I agree that I will pay $25.00 for any missed visit where I have failed to notify this office.**

_____ _____

PRINT PATIENT NAME PRINT PARENT/GUARDIAN NAME

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

_____

RELATIONSHIP TO PATIENT IF PARENT OR GUARDIAN

THE CENTERS FOR ADVANCED ENT CARE
Chesapeake Otolaryngology Division

4000 Mitchellville Road, Ste A414
Bowie, MD 20716
Phone: (301) 860-0985
Fax: (301) 860-0978

**Gail J. Anderson, M. D. FACS**
**Katherine S. Perry, M.D.**
**Manan U. Shah, M.D.**
**Lynne A. Jacobs, DNP CRNP**

131 Main St, Ste 202
Prince Frederick, MD 20678
Phone: (410) 535-6975
Fax: (410) 535-6915

# PRIVACY PRACTICES ACKNOWLEDGEMENT

## ACKNOWLEDGEMENT FORM

*I understand that my written permission is necessary for protected health information to be released to anyone including family or friends who may be involved in my treatment or care except as permitted or required by law.*

**I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.**

**Patient's Printed Name** _____ **Patient's Birthdate** _____

**Patient/Parent/Guardian Signature** _____

**Date** _____

Please see the front desk to review a copy of our Privacy Practices.

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

**I HEREBY GIVE PERMISSION FOR MEDICAL INFORMATION TO BE LEFT ON MY VOICE MAIL/ANSWERING MACHINE AT THE FOLLOWING NUMBER (S):**

_____ **HOME** _____ **WORK** _____ **CELL**

**I HEREBY GIVE PERMISSION FOR THE FOLLOWING NAMED PERSON (S) TO RECEIVE MEDICAL INFORMATION ON MY BEHALF:**

_____ **NAME** _____ **RELATIONSHIP**

_____ **NAME** _____ **RELATIONSHIP**

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# *(PATIENT FINANCIAL RESPONSIBILITY)*

Please be aware that certain insurances may consider procedures performed in our office as "surgery" and not included in the standard office visit charges. These procedures will be **billed separately** and **in addition to** the office visit charges. Because some insurance carriers are classifying these procedures as "surgery" they are applying the charges to a higher deductible and /or copay amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure **will be due from the patient**. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of the patient.

Examples of in-office procedures include:

Flexible laryngoscopy: This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen. If you are complaining of throat or ear problems, the provider may need to perform this exam to adequately diagnose the problem.

Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue. This is often performed for patients who are following up after sinus surgery, to assist in the healing of the tissues.

Nasopharyngolcopy: This procedure is used to visualize the back of the nose and Eustachian tubes.

Removal of impacted wax from the ear:

Audiological Testing to include hearing and balance testing:

Please speak with our staff if you have any questions.

_____ _____
Patient Signature Date

_____
Printed Name

1. Have you seen any ear, nose or throat specialists within the past 3 years?_____yes _____no
   If so, who and where
   _____

2. Have you had any operations on your ear, nose, throat or neck in the past 3 years? _____ yes _____no

   If so, please provide the name of the surgeon and hospital
   _____

   _____

Patient Name (please print)
_____

Signature_____
Date_____