BECKER
EAR, NOSE & THROAT CENTER

How did you hear about us?_____

Patient Identification

Patient Name: _____ Date of Birth: _____

Social Security: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D W ☐

Street Address: _____ City: _____ State: _____ Zip: _____

Phone #s (H): _____ (C): _____ (W): _____

Email Address: _____

Are you currently employed? Y ☐ N ☐ Name of Employer: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Family Members involved in your care. (Name & Relationship):

Person to contact in case of an emergency: _____ Phone #: _____

The following demographic questions are a requirement of the Center for Medicare and Medicaid Services Meaningful Use Program. The questions are written exactly as specified on the federal register that outlines the rules and regulations for Meaningful Use. We kindly request that you answer to the best of your ability.

What is your race?

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Hispanic

☐ Other ☐ Decline to Specify

What is your ethnic background?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

What is your preferred language?

☐ English ☐ Sign Language ☐ Spanish ☐ Other ☐ Decline to Specify

At Becker ENT we take great efforts to provide optimal communication between the practice and our patients. On occasion is it useful to communicate via texting (SMS to cell phone). Texting is not used for communication of health care information, but for items such as appointment reminders, office closures due to weather, ect. You may, of course, unsubscribe at any time from texting if you change your mind. Please review and sign your preference below.

☐ I give Becker ENT permission to send me text messages (Please list preferred number to receive messages).

Phone Number: _____

☐ I do not give Becker ENT permission to send me text messages.

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PRIMARY INSURANCE

Primary Insurance Carrier: _____ Address: _____

Subscribers Name: _____ Relationship: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____ Subscriber SS#: _____

SECONDARY INSURANCE

Secondary Insurance Carrier: _____ Address: _____

Subscribers Name: _____ Relationship: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____ Subscriber SS#: _____

OTHER MEDICAL INFORMATION

Primary Physician: _____ Address/Phone Number: _____

Name / Phone # of any other Dr. you see on a regular basis: _____

Pharmacy Name, Town and Phone #: _____

All lab costs are separate from our fees. We are not responsible for charges that are not covered by your insurance company. Please check which lab your insurance covers: ☐ Quest Lab Corp ☐

Referral Acknowledgement

Dear
Patient

There are many different kinds of health insurance, each of which has its own set of requirements for referrals. While we are happy to help you understand the details of your policy, it is ultimately a patient's responsibility to know whether or not they need to have a referral. If you do not have a referral for your visit, your insurance company may not pay for the services billed, and the payment will become your responsibility. Please make sure that you have a proper and up to date referral if your insurance plan requires one.

I acknowledge that I have read and understand this statement above. It is my responsibility to make sure that I have a referral for evaluation and treatment.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

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New Patient Health Survey

Date: _____

Patient Name: _____ Date of Birth: _____

Sex: M ☐ F ☐ Referring/Family Doctor: _____ Tel #: _____

Please describe the reason(s) for your visit: _____

From the list of symptoms below, **CHECK** the ones you have:

NOSE AND SINUS

- ☐ Allergy symptoms (sneezing, itchy nose/eyes/throat, runny nose)
- ☐ Nasal blockage
- ☐ Postnasal drip
- ☐ Discolored nasal drainage
- ☐ Nasal bleeding
- ☐ Sinus infections
- ☐ Facial pressure
- ☐ Headache or facial pain
- ☐ Snoring/sleep problems
- ☐ Halitosis (bad breath)
- ☐ Decrease in smell or taste
- ☐ Cough
- ☐ Tooth pain
- ☐ **OTHER** _____

THYROID/NECK

- ☐ Swollen lymph nodes or neck mass
- ☐ Thyroid nodule

EARS

- ☐ Hearing loss/ear fullness
- ☐ Ringing
- ☐ Dizziness
- ☐ Ear infections

THROAT/VOICE

- ☐ Heartburn/reflux
- ☐ Hoarseness
- ☐ Difficulty swallowing

When did the problem(s) start? _____ Rate severity of the problem on a scale of 1 to

What makes it worse? _____

What makes it better? _____

Describe any pain (e.g. throbbing, dull, or sharp), its location, and its severity on a scale of 1 to 10:

_____

What type of treatments/medications have you received for this/these problems?

_____

	Yes	No
Do you have **environmental allergies**?	☐	☐
Have you had **allergy shots**?	☐	☐
Do you have **asthma**?	☐	☐
Do you have **migraines**?	☐	☐

Alcohol/Drug History

Do you drink alcohol?	☐	☐
If yes, when? _____		
Do you use any street drugs?	☐	☐
If yes, what type? _____		

	Yes	No
Do you have a **thryoid nodule**?	☐	☐
Have you ever had a **neck/thyroid ultrasound**?	☐	☐
Any **skin growths** that have changed?	☐	☐

Smoking History

Do you smoke?	☐	☐
If yes, please indicate___ packs per day for ___ year(s).		
Did you quit smoking?	☐	☐
If yes, when? _____		
Are you exposed to second-hand smoke?	☐	☐

Patient Name: _____

Past Medical History: Please **CHECK** any of the following medical conditions, if you have ever had them:

- ☐ AID/HIV
- ☐ Alcohol or drug abuse
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Benign tumors
- ☐ Bladder/bowel incontinence
- ☐ Bleeding disorder
- ☐ Bowel irregularity
- ☐ Bronchitis
- ☐ Calf/leg cramping
- ☐ Cancer
- ☐ Cerebral aneurysm
- ☐ Clotting disorder
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Disc injury
- ☐ Dizziness or fainting
- ☐ Emphysema
- ☐ Environmental toxin exposure
- ☐ Gallbladder
- ☐ GERD
- ☐ GI disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Heart attack (MI)
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Heart rhythm disturbance
- ☐ Hepatitis
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Liver disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Mitral valve prolapse
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Obstructive sleep apnea
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Seizure/epilepsy
- ☐ Sexual dysfunction
- ☐ Sickle cell
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ UTI
- ☐ Other: _____

Past Surgical History: Please **CHECK** any of the following surgeries/procedures that you have had:

- ☐ Adenoidectomy
- ☐ Amputation
- ☐ Appendectomy
- ☐ Bladder surgery
- ☐ Blood transfusion
- ☐ Bowel resection
- ☐ Cardiac bypass
- ☐ Cardiac catheterization
- ☐ Chemotherapy
- ☐ D & C
- ☐ Dialysis
- ☐ Disc surgery
- ☐ Gallbladder surgery
- ☐ Inferior turbinate reduction
- ☐ Joint replacement
- ☐ Kidney surgery
- ☐ Laparoscopy
- ☐ Lens implant
- ☐ Open heart surgery
- ☐ Organ transplant
- ☐ Pacemaker
- ☐ Radiation therapy
- ☐ Rhinoplasty
- ☐ Septoplasty
- ☐ Sinus surgery
- ☐ Snoring surgery
- ☐ Tonsillectomy
- ☐ Transurethral resection of prostate (TURP) Other: _____

Review of Systems: Please **CHECK** if you recently have had any of the following:

Constitutional

- ☐ Hearing loss/ear ringing
- ☐ Fatigue
- ☐ Weight gain/loss
- ☐ Fever/chills/night sweats

Eyes

- ☐ Corrective lenses
- ☐ Eye pain or tearing
- ☐ Double vision

Cardiovascular

- ☐ Chest pain/tightness
- ☐ Shortness of breath
- ☐ Heart attack
- ☐ Leg pain when walking
- ☐ Swelling of hands/feet/legs

Gastrointestinal

- ☐ Heartburn
- ☐ Pain on swallowing
- ☐ Loss of appetite
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Change in bowel Habits
- ☐ Bloody stool
- ☐ Hemorrhoids

Musculoskeletal

- ☐ Joint pain or swelling
- ☐ Muscle pain/bone pain

Skin

- ☐ Changing moles
- ☐ Itching
- ☐ Rashes or ulcers
- ☐ Skin color/texture change

Neurological

- ☐ Frequent headaches
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors

Psychiatric

- ☐ Anxiety
- ☐ Depression

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Patient Name: _____

Review of Systems (cont.): Please **CHECK** if you recently have had any of the following:

Respiratory

- ☐ Snoring/sleep apnea
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Frequent sore throats

Allergy/Immunology

- ☐ Seasonal allergies

Genitourinary

- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Difficulty/hesitancy on urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Impotence
- ☐ Prostate problem
- ☐ Menstrual problem

Endocrine

- ☐ Thyroid problems
- ☐ Frequent thirst
- ☐ Heat/cold intolerance

Hematologic/Lymphatic

- ☐ Easy bruising/bleeding
- ☐ Swollen lymph nodes

List all medications that you are presently taking with the dosage:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Are you allergic to any medications? ☐ Yes ☐ No

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Do you take Aspirin/Aspirin Products? ☐ Yes ☐ No

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Family/Social History: Please **CHECK** any of the listed diseases that run in your family (if none, check "None"):

	Father	Mother	Brother	Sister
Thyroid	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Bleeding tendencies	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Atopic Dermatitis (eczema)	☐	☐	☐	☐
None	☐	☐	☐	☐
Other: _____				

Have you been hospitalized in the last 5 years? Yes ☐ No ☐
If yes, why?: _____

Are you pregnant (Women only)? ☐ Yes ☐ No
If yes, how many months? : _____
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature: _____ Date: _____

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Contract for Evaluation and Treatment

I understand that as part of my medical care, my Becker ENT physician may prescribe or recommend various medications. I understand that any medication may have unintended side effects, interactions, and complications, sometimes in combination with other medications. Most of these are discussed on the medication inserts. I agree to read these inserts so that I understand the risks associated with any prescribed medication. I agree to ask my Becker ENT physician at my appointment, or by phone after my appointment if I have any further questions about the prescribed or recommended medications. I agree that I will not take any medications until my questions have been answered in a manner that is satisfactory to me.

My Becker ENT physician may also prescribe for me to have further evaluation such as a blood work, cultures, CT scan, MRI, or a hearing and/or balance test. He may also recommend further evaluation by a gastroenterologist, laryngologist, neurologist, head and neck surgeon, or other medical specialist. I understand that further evaluation is often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

I understand that for any prescribed or recommended blood test, cultures, imaging test (CT, MRI), or evaluation (balance/hearing test) I should not consider this evaluation complete until I follow up with my Becker ENT physician to review the results of these test/evaluations. In the case of referral to another specialist I also understand that it is my (the patient's) responsibility to arrange and attend this appointment. If I have any difficulty doing so I will contact my Becker ENT physician and ask for assistance. Again, I understand that these evaluations and referrals are often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Physician Signature: _____ Date: _____

Physician Name (Print): _____

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Patient Name: _____

Date of Birth: _____ Today's Date: _____

Patient Consent & Attestation – Nasal Endoscopy/Laryngoscopy/Debridement

NASAL ENDOSCOPY involves examining the nose/sinus/nasopharynx areas with direct vision using either a rigid endoscope or a flexible fiber optic endoscope. **FLEXIBLE LARYNGOSCOPY (NPL)** involves examining the throat/voice box areas with direct vision using a flexible fiber optic endoscope. Sprays may be used to decongest and/or numb the nasal passage and throat prior to endoscopic examination.

YOUR CONSENT:

The procedure and description of this procedure, the more common risks associated with it, and the potential complications have been described to me. This includes, but is not limited to: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize physicians at the Becker ENT Center to perform a rigid sinus-nasal endoscopy and/or a flexible nasopharyngolaryngoscopy (NPL). **I hereby authorize the doctor to provide such additional services as he may consider medically advisable, including, but not limited to suctioning, culturing the drainage, debridement of the sinus and nasal passages, biopsies, and packing if needed.** I also consent to the use of photographs/video images to advance medical education and understand that if any photographs are used, I will not be identified by name. I confirm that all of my questions on this subject have been answered to my satisfaction, and I would like the physician to proceed with Nasal Endoscopy/Flexible Laryngoscopy as indicated. This consent is valid for one year as of today's date. **Endoscopy is a separate procedure, it is not included in the cost of an office visit and is billed to you insurance company separately from your office visit.**

Patient/Guardian Signature: _____ Date: _____

ATTESTATION: DIAGNOSTIC NASAL ENDOSCOPY - The doctor placed a lighted metal rod into my nose, sinus and nasopharynx area. I verify that the doctor performed Nasal Endoscopy on me today. This Endoscopy had the following characteristics:

A. Topical Decongestion ☐ Yes ☐ No B. Topical Anesthesia ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

ATTESTATION: FLEXIBLE NPL - The doctor placed a flexible scope through my nose, to examine my nose and throat. I verify that the doctor performed Diagnostic Flexible NPL on me today, with the following characteristics:

A. Topical Decongestion ☐ Yes ☐ No B. Topical Anesthesia ☐ Yes ☐ No

Patient / Guardian Signature: _____ Date: _____

ATTESTATION: NASAL ENDOSCOPY WITH DEBRIDEMENT - The doctor placed a lighted metal rod into my nose, sinus and nasopharynx area and using suction and other instruments, removed crusting and debris from the nasal and sinus passages. I verify that the doctor performed Nasal Endoscopy on me today. This Endoscopy had the following characteristics:

A. Topical Decongestion ☐ Yes ☐ No B. Topical Anesthesia ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

I have reviewed all information in the health survey and discussed it with the patient/guardian. I performed the procedure(s) circled indicated.

Attending Physician Signature: _____ Date: _____

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Financial Policy

Becker Ear, Nose & Throat Center is committed to providing you with the best medical care possible. We will gladly discuss your proposed treatment with you and answer any questions.

We are happy to do our best to answer any questions regarding your health insurance coverage, but you must understand that your insurance contract is between you and your insurance company. We are not party to the contract and so we suggest that you speak to your carrier to get a clear understanding of their policies. Our relationship is with you and not with your insurance company.

If you have commercial Medical Insurance or Medicare, we will submit claims directly to the carrier. You must realize that not all services are covered by all insurance carriers. Each carrier determines what they will cover (pay for).

We participate in some insurance plans and not in others. If we are not participating providers in your medical insurance plan, then your medical insurance plan may pay some of the charges for care provided, but you are responsible for charges and fees not paid by the medical insurance company.

In most cases, your insurance company will cover the cost of a Hearing Test. An examination of 50 consecutive patients at the Becker ENT Center found that 90% (45/50) had complete coverage for their testing. If you would like to know for certain whether or not your hearing test will be covered, we encourage you to call your insurance company and inquire. If you have no coverage, your maximum out-of-pocket expense will be $90.

Have we notified you whether or not we participate in your medical insurance plan? ☐ Yes ☐ No

Payments for services, including co-payments, are due at the time care is provided. We accept cash, checks, Visa, MasterCard, and American Express. Any payment received directly by you from your insurance company for services rendered by our health care providers must be sent to our office immediately.

Returned checks may be subjected to a fee of $25.

As always, we are committed to providing you with personalized care in a comfortable setting. Please feel free to discuss our financial policy with any member of our practice.

By signing this form you are giving us authorization to submit medical claims on your behalf to your Medical Insurance Carrier or your Medicare Carrier. You are also giving us authorization to have your Medical Insurance/Medicare Carrier release information pertaining to your benefits or your benefits payable for related services to us. Also you request that payment of authorized benefits be made on your behalf to Becker Ear, Nose & Throat Center for any service furnished by said physician and/or audiologist.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Becker ENT Center Staff: _____Date: _____