



**EAR
NOSE &
THROAT**
ASSOCIATES OF SECT

PATIENT REGISTRATION

PATIENT NAME: _____ DOB: _____

NAME OF PERSON COMPLETING FORM (if different from above): _____

RELATION TO PATIENT: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PROVIDER: _____

INSURANCE INFORMATION (COMPLETE ONLY IF YOU DO NOT HAVE INSURANCE CARD)

PRIMARY INS CO. _____ ID# _____ Group# _____

SECONDARY INS CO. _____ ID# _____ Group# _____

NAME OF PERSON RESPONSIBLE FOR INSURANCE: _____ DOB: _____
(if different from above)

CONTACT INFORMATION

HOW WOULD YOU PREFER TO BE CONTACTED BY OUR OFFICE FOR APPOINTMENT REMINDERS?
(check all that apply)

Phone call/voicemail #: _____

Text message #: _____

Email address: _____

EMERGENCY CONTACT (RELATION TO PATIENT): _____

PHONE#: _____

May we leave test results and/or discuss your medical condition with family members?

YES NO

May we leave test results on your voice mail?

YES NO

Please list the name(s) of anyone you designate as your personal representative to discuss protected health information if required.

SIGNATURE: _____ DATE: _____



Past Medical, Social & Family History

PATIENT NAME: _____

Height: _____ Weight: _____ Name of Health Care representative (if applicable): _____

PAST MEDICAL HISTORY/ALLERGIES

Check if YOU have ever had any of these conditions:

- Asthma Thyroid Disease High Blood Pressure Strokes Sleep Apnea
 COPD Diabetes Heart Disease Acid Reflux Migraines
 HIV/AIDS Bleeding disorder Pacemaker/Defibrillator Kidney/Renal Disease Opioid Use Disorder
 Cancer (Type): _____
 Problems with anesthesia (describe): _____
 MEDICATION OR LATEX ALLERGIES (please list): _____
-

PAST EAR NOSE OR THROAT SURGERIES (YEAR):

- Sinus surgery _____ Tonsils/adenoids _____ Thyroidectomy _____
 Septoplasty _____ Ear tubes _____ Salivary gland _____
 Other nasal surgery _____ Other ear surgery _____ Neck/cervical surgery _____
 Other ENT surgery _____
-

SOCIAL HISTORY

- Alcohol - amount per week: _____
 Tobacco (smoke, vape, chew) amount per day: _____
 Caffeine (coffee, tea, soda, chocolate) amount per day: _____
-

FAMILY HISTORY

Check if any IMMEDIATE family members have ever had any of these conditions:

- Bleeding disorder Hearing Loss (not age-related) Thyroid cancer
 Problems with anesthesia (describe): _____
-

I certify that information is true and correct to the best of my knowledge.

Patient's Signature _____

Date: _____



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ASSOCIATES OF SECT

PATIENT NAME: _____

INSURANCE WAIVER:

You are asked to sign this waiver because of the ever changing rules and regulations of the insurance industry. In the past, our office has obtained prior authorizations and/or referrals for our patients from their primary care physicians for services performed in our office. We participate with many insurance companies and unfortunately there are many different plans under each insurance carrier and/or employer group plan. It is impossible for our office staff to stay abreast of all the rules and regulations set forth by each insurance carrier. Our staff spends long periods of time on hold waiting to speak to other offices and/or insurance carriers to obtain what is needed in order for office visits/testing to be covered. By signing below, you are indicating that you are aware and responsible to obtain any/all referrals or authorization required by your insurance carrier to be seen in a specialist office. Most insurance carriers will not back date an authorization for you. It is very important to know what kind of insurance you have and know all their requirements. This is an agreement between you and your insurance carrier. We are not a party to that agreement. We will submit your claim on your behalf to your insurance carrier. If authorization and/or referrals are not obtained prior to your appointment, and your insurance carrier denies your claim, you will be fully responsible for the charges. You are stating that you are aware of your insurance requirements and have obtained all necessary referrals and/or authorizations from your primary care physician. If you are not sure of your benefits, please feel free to contact your insurance carrier for clarification. You also understand and agree, to provide our office with any new coverage prior to services being rendered. Finally, you agree that we may request and use prescription medication history from other providers including digital downloads from pharmacies and/or third party pharmacy benefit payors. PLEASE INITIAL BELOW TO ACKNOWLEDGE YOUR UNDERSTANDING.

Initial: _____

OFFICE PROCEDURES POLICY:

Please understand that some commonly performed parts of your ENT examination in this office MAY include Mirror Examinations of the Vocal Cords/ larynx and/or nasopharynx, and/or FIBEROPTIC EXAMINATIONS of the nose and or 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/or 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. PLEASE INITIAL TO ACKNOWLEDGE YOUR UNDERSTANDING OF THIS POLICY SO THAT YOUR PHYSICIAN MAY PROCEED WITH A PROCEDURE IF IT IS INDICATED.

Initial: _____

HIPPA COMPLIANCE/CONTACT INFO (Kimberly Carr, Practice Manager/HIPPA Officer (860) 442-0407 x 226)

Please initial below to acknowledge receiving Ear, Nose and Throat Associates of Southeastern Connecticut's Privacy Notice.

Initial: _____

NO SHOW/ LATE CANCELLATION (UNDER 24 HOURS)

Our office has the right to charge \$45.00 for no shows and/or late cancellations. We consider a late cancellation under 24 hours.

Please initial below to acknowledge your understanding of this policy.

Initial: _____

SIGNATURE _____

DATE: _____