EAR
NOSE &
THROAT
ASSOCIATES OF SECT

PATIENT REGISTRATION

PATIENT NAME: ____________________ DOB: ____________

PARENT/GUARDIAN NAME: ____________________ DOB: ____________

HOME ADDRESS: ________________________________

CITY: ____________________ STATE: __________ ZIP: __________

REFERRING PHYSICIAN: ______________ PRIMARY CARE PROVIDER: ______________

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

CONTACT INFORMATION

HOW WOULD YOU PREFER TO BE CONTACTED BY OUR OFFICE FOR APPOINTMENT REMINDERS?

Phone call/voicemail #: ________________________________

Text message #: ________________________________

Email address: ________________________________

EMERGENCY CONTACT: ____________________ PHONE#: ____________

INSURANCE INFORMATION

PRIMARY INS CO. ______________ ID# ______________ Group# ______________

NAME OF PERSON RESPONSIBLE FOR INSURANCE: ______________ DOB: ______________

SECONDARY INS CO. ______________ ID# ______________ Group# ______________

NAME OF PERSON RESPONSIBLE FOR INSURANCE: ______________ DOB: ______________

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:** ____________________

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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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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:** ______________