Information Form Set

If you have used our patient portal, you need only sign the following page. You must then fill out the remaining pages completely.

When you have completed the following pages, you may fax them to our office at: (845) 727-1349

Please remember to bring:

1) Active Insurance Card
2) A photo ID
3) An active referral, if needed
4) X-rays, lab reports or other information that will make your visit more productive

Print Form

PATIENT DEMOGRAPHICS

Patient Last Name: Patient First Name: Sex: M F

Home Address:

Date Of Birth: Age: Social Security Number (Patient):

Home Phone #: Cell Phone # E-mail Address:

Work Phone #: Employer Name:

If Patient is **UNDER** 18 - Parent/Guardian Name: Social Security # (Guardian):

Parent/Guardian Phone #:

REFERRING DOCTOR

Name:

Address:

Office Phone #:

PHARMACY

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone #: Pharmacy Fax #:

EMERGENCY CONTACT

Name:

Relationship To Patient:

Contact Phome Home #: Contact Cell Phone #: Contact Work Phone #:

PRIMARY INSURANCE INFORMATION

Insurance Company Name:

Phone #:

Policy Holder Name: Policy ID #:

SECONDARY INSURANCE INFORMATION

Insurance Company Name:

Phone #:

Policy Holder Name: Policy ID #:

GUARANTOR INFORMATION

Subscriber Name (Policy Holder):

Subscriber Social Security #:

Address:

Date Of Birth: Relationship To Patient:

Employer Name:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers or to the billing agent of this physician , any information needed for this or a related Medicare claim. I permit a copy of his authorization to be used in place of the original, and request payment of insurance benefits either to myself or the party who accepts assignment.

*Name*_____ *Signature*_____ *Date*_____

I authorize you to remit all medical benefits directly to Rockland Ear Nose and Throat Associates, P.C.

*Name*_____ *Signature*_____ *Date*_____

ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C.
Health Information Form: Page One

Patient Last Name: Patient First Name: Birth Date: Today's Date: Height: Weight:

DOCTOR WHO SENT YOU HERE:

1) WHAT IS THE REASON FOR TODAYS VISIT?

2) PAST MEDICAL HISTORY (Click All That Apply)

☐ Heart Disease	☐ Allergy/Hay Fever	☐ Diabetes/Sugar	☐ High Blood Pressure
☐ Alcoholism	☐ Thyroid Problem/Goiter	☐ Mental Illness/Retardation	☐ Arthritis
☐ Depression	☐ Irregular Heart Beat	☐ Glaucoma	☐ Migraines
☐ Asthma/Bronchitis/Lung	☐ Tuberculosis	☐ Bleeding Disorder/Anemia	☐ Urine/Kidney Disease
☐ Stroke	☐ AIDS/HIV	☐ Lyme Disease	☐ High Cholesterol
☐ Epilepsy/Seizures	☐ Liver Disease/Hepatitis	☐ Reflux/Ulcer	☐ Bone Fractures
☐ Otosclerosis	☐ Prostate	☐ Menieres Disease	☐ Deafness
☐ Osteoporosis	☐ Cancer-Where	☐ Radiation Therapy?	☐ Chemotherapy?

Anesthesia Problems

3) PAST SURGICAL HISTORY

4) LIST YOUR CURRENT MEDICATIONS (prescription, over-the-counter, vitamins, herbals, aspirin, birth control, etc.):

5) DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR LATEX?

6)FAMILY HISTORY (Click All That Apply & Write In Family Member If Possible)

☐ Heart Disease	☐ Diabetes/Sugar	☐ High Cholesterol	☐ Arthritis
☐ High Blood Pressure	☐ Anesthesia Problems	☐ Thyroid Disease	☐ Migraines
☐ Lung Disease/Asthma	☐ Hay Fever/Allergies	☐ Bleeding Disorder	☐ Anemia
☐ Hearing Loss	☐ Otosclerosis	☐ Menieres Disease	☐ Osteoporosis
☐ Alcoholism	☐ Cancer	☐ Mental Illness	☐ Epilepsy

7) SOCIAL HISTORY

Job Description Or School Grade

Do YouSmoke? Packs A Day? # of Years? Did You Ever Smoke? When did You Quit? Second Hand Smoke?

How Many Cups Of Caffeinated Beverages Per Day? (Coffee, Tea Or Soda)?

How Often & How Much Alcohol Do You Drink?

What Kind Of Pets Do You Have?

Are you Single? Married? # Of Children Vaccines Up-To-Date?

Are You Pregnant? PAP Smear Less than 3 Years Ago? Types Of Exercise & Frequency Special Diet?

8) OTHER/ COMMENTS

OFFICE USE ONLY!

Reviewed By _____

ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C.
Health Information Form: Page Two

Patient Last Name: _____ Patient First Name: _____ Birth Date: _____ Today's Date: _____

9) REVIEW OF SYSTEMS (check all that apply)

General Symptoms:
- ☐ Fever
- ☐ Night Sweats
- ☐ Appetite Change
- ☐ Weight Change
- ☐ Sleeping Problems
- ☐ Born Prematurely

Eyes:
- ☐ Vision Changes
- ☐ Eye Infections
- ☐ Itchy/Watery

Ears:
- ☐ Decreased Hearing
- ☐ Ear Infections (#/yr) _____
- ☐ Ringing/Noises
- ☐ Ear Pain
- ☐ Dizzy Spells/Vertigo
- ☐ Hearing Aids
- ☐ Drainage/Odor
- ☐ TMJ Disorder
- ☐ Ear Wax
- ☐ Trouble Popping
- ☐ Q-Tip Use

Nose:
- ☐ Nosebleeds
- ☐ Broken/Deviated Septum
- ☐ Congested
- ☐ Sneezing/Allergies
- ☐ Nasal Pain
- ☐ Poor Sense Of Smell
- ☐ Nasal Polyps
- ☐ Sinus Infections (#/yr) _____
- ☐ Post-Nasal Drip

Mouth/Throat:
- ☐ Sore Throat
- ☐ Tonsil Infections (#/yr) _____
- ☐ Vocal Cord Polyps
- ☐ Mouth Lesions
- ☐ Hoarsness/Laryngitis
- ☐ Speech Delay
- ☐ Tooth/Dental Problems
- ☐ Cleft Lip/Palate
- ☐ Bad Breath

Cardiovascular:
- ☐ Chest Pain/Palpitations
- ☐ Heart Murmur
- ☐ Swollen Ankles

Respiratory:
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Sputum Increase
- ☐ Shortness Of Breath
- ☐ Snoring
- ☐ Sleep Apnea/CPAP

Gastrointestinal:
- ☐ Swallowing Difficulty
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ GI Bleeding
- ☐ Change In Bowel Habits

Genitourinary:
- ☐ Frequent Urination
- ☐ Urine Infections
- ☐ Venereal disease
- ☐ Prostate Problems
- ☐ Menopause
- ☐ Pregnancy Problems
- ☐ Breast Disease
- ☐ Breast Feeding?

Musculoskeletal:
- ☐ Weakness
- ☐ Joint Pains
- ☐ Muscle Cramps

Skin:
- ☐ Rashes
- ☐ Itching
- ☐ Skin Lesions

Neuropsychiatric:
- ☐ Seizures
- ☐ Tremor
- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric Care
- ☐ Drug/ETOH Addiction
- ☐ Increased Stress

Endocrine:
- ☐ Heat/Cold Intolerance
- ☐ Increased Thirst

Hematological:
- ☐ Blood Transfusions
- ☐ Bruise Easily

Allergic/Immunoologic:
- ☐ Seasonal
- ☐ Food
- ☐ Receive Shots?

Other/Comments: _____

Reviewed By _____

HIPAA ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C. Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Date:_____ _____

Patient's Signature

In addition, I _____ hereby permit and acknowledge that ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C. will access my prescription medication history through Surescripts, or other third party prescription data services, in order to better document our own patient prescription drug records.

Date:_____ _____

Patient's Signature

Rockland Ear Nose & Throat Associates, PC

Shelley R. Berson MD FACS, FAAOA

2 Strawtown Road

West Nyack, NY 10994

(845) 727-1340 (845) 727-1349 fax

www.rocklandent.com

As a courtesy to you, our office employs a billing company and participates with several insurance carriers. Every program is different. Please familiarize yourself with your insurance's practices and policies, including authorizations and lab facility requirements.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (copays, deductibles), we are legally required to collect these. No exceptions will be made. You are required to pay your copay at the time of your visit.
2. If your insurance carrier requires you to have a referral, please provide a valid, active and timely referral or you will not be seen.
3. If your insurance company requires you to meet an annual deductible before your healthcare fees will be covered by them, you will be billed for the services rendered if you have not met that deductible.

   I acknowledge receipt of this information _____.
4. You will be asked to leave a credit/debit card number at the time of check in. This information will be held securely until your insurances have paid their portion and notified us of your personal remaining balance. At that time this remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you. We will make every effort to contact you before processing the charge.

   I _____ authorize Rockland Ear Nose & Throat to charge outstanding balances to the following credit card:

   Discover (Account/Exp. Date) _____

   MasterCard (Account/Exp. Date) _____

   Visa (Account/Exp. Date) _____

   HSA (Account/Exp. Date) _____

   Name on card_____

   Signature_____

   Date_____

MEDICARE PATIENTS ONLY

Name of Patient

Health Insurance Claim #

I request that payment of authorized Medigap/supplemental benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) sopplier. I authorize and holder of Medicare information about me to release to:

Name of Medigap Insurance

any information needed to determine these benefits payable for related services.

_____

Patient Signature

_____

Date

ROCKLAND EAR, NOSE & THROAT ASSOCIATES, P.C.

SHELLEY R. BERSON M.D., F.A.C.S. , F.A.A.O.A.

2 Strawtown Road
West Nyack, New York 10994
www.rocklandent.com
(845) 727-1340
(845) 727-1349 fax

OFFICE CANCELLATION POLICY

PLEASE BE AWARE THAT IF AN APPOINTMENT IS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE CHARGED A FEE OF $25.00.

THIS FEE IS NOT COVERED BY YOUR INSURANCE COMPANY.

THANK YOU FOR YOUR COOPERATION.

Signature_____ **Date**_____

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:_____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with his information. Please rate your problems as they have been over the past two weeks.

Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is y circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as Bad as It Can Be		5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5		O
2. Nasal Blockage	0	1	2	3	4	5		O
3. Sneezing	0	1	2	3	4	5		O
4. Runny Nose	0	1	2	3	4	5		O
5. Cough	0	1	2	3	4	5		O
6. Post-nasal discharge	0	1	2	3	4	5		O
7. Thick nasal discharge	0	1	2	3	4	5		O
8. Ear fullness	0	1	2	3	4	5		O
9. Dizziness	0	1	2	3	4	5		O
10. Ear Pain	0	1	2	3	4	5		O
11. Facial Pain	0	1	2	3	4	5		O
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		O
13. Difficulty Falling Asleep	0	1	2	3	4	5		O
14. Wake Up At night	0	1	2	3	4	5		O
15. Lack Of A Good Night's Sleep	0	1	2	3	4	5		O
16. Wake Up Tired	0	1	2	3	4	5		O
17. Fatigue	0	1	2	3	4	5		O
18. Reduced Productivity	0	1	2	3	4	5		O
19. Reduced Concentration	0	1	2	3	4	5		O
20. Frustrated/restless/irritable	0	1	2	3	4	5		O
21. Sad	0	1	2	3	4	5		O
22. Embarrassed	0	1	2	3	4	5		O

2. Please mark the most important items affecting your health (maximum of 5 items) _____