HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO OBTAIN THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

In the course of your care as a patient at Rockland Ear, Nose, and Throat Associates, PC, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further testing, assessment, or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as: an insurance carrier, an HMO, a PPO, or your employer.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Furthermore, you have the right to inspect or obtain a copy or the information we will use for these purposes. You also have the right to refuse to provide authorization for this office regarding those matters. Should you decide to not provide us such authorization, your care will not be affected in this office.

Under federal law, we are also permitted or required to use or disclose your health information without consent or authorization in the following circumstances:

- Should we provide services to you based on the orders of another healthcare provider
- Should we provide services to you as an emergency
- Should we be required by law to provide care to you and are unable to obtain your consent after attempting to do so
- Should there be substantial communication barriers between you and our office and our office's professional judgment believes you intend for our office to provide care
- Should we be ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive care.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our file. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient files and health protect information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Should changes be made to our privacy notice, we will notify you in writing as soon as possible. Should you have any concern regarding: the information that we use or disclose based on this privacy notice, our privacy practices, or any aspect of our privacy activities, please direct your concerns to Susan E. Predmore, Practice Manager. This notice is effective as of June 1, 2017, and will expire seven years after the date it was created.

_____	_____	_____
Patient Name	Patient Signature	Date

Patient Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS

What is the main reason for today's visit?

◯ Ear ◯ Nose ◯ Throat ◯ Allergy ◯ Sleep ◯ Dizzy

How would you describe the problem?

_____

On a scale from 1 – 10 (10 being the worst), how would you rate your discomfort? _____

How long has this been going on? _____

Have you tried anything for this? (If so, what have you tried?)

_____

What makes it better? _____

What makes it worse? _____

Are there any other issues you would like to discuss today?

_____

Do you have any new medical conditions or medications since your last visit?

_____

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ◯ Yes ◯ No

Do you often feel tired, fatigued, or sleepy during the day? ◯ Yes ◯ No

Has anyone observed you stop breathing during sleep? ◯ Yes ◯ No

Do you have or are you being treated for high blood pressure? ◯ Yes ◯ No

MEDICATION RECORD

Please list all of your current medications including: over-the-counter, vitamins, herbal supplements, and medications you take as needed.

MEDICATION	STRENGTH	FREQUENCY

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Gender M F | Language other than English

Home address | Apt # | City | State | Zip Code

Home Phone | Cell Phone | Email address

INSURANCE GUARANTOR (RESPONSIBLE PARTY)

Relationship to patient: Self (If self, skip to next section) Spouse Parent Other

Last Name | First Name | Middle Initial / Nickname

Date of Birth | Gender M F | Language other than English

Home address | Apt # | City | State | Zip Code

Home Phone | Cell Phone

PHYSICIAN INFORMATION

Primary Care Physician | Address | Phone Number

Pharmacy Name | Address | Phone Number

EMERGENCY / NEXT OF KIN INFORMATION

Last Name | First Name | Relationship to Patient

Emergency Contact Phone Number

HEALTH INFORMATION, page 1

Today's Date: _____

Patient Last Name: _____ Patient First Name: _____ Birth Date: _____ Height: _____ Weight: _____

DOCTOR WHO SENT YOU HERE: _____

1) WHAT IS THE REASON FOR TODAY'S 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?

Other _____

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)

☐ Heart Disease	☐ Diabetes/Sugar	☐ High Cholesterol	☐ Arthritis
☐ 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 You Smoke? ☐ 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: _____ Special Diet? : _____

8) OTHER/COMMENTS

Patient Name: _____ DOB: _____ 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	☐ Hoarseness/Laryngitis	☐ Speech Delay
	☐ Dental Problems	☐ Cleft Lip/Palate	☐ Bad Breath
Cardiovascular	☐ Chest Pain/Palpitations	☐ Heart Murmur	☐ Swollen Ankles
Respiratory	☐ Chronic Cough	☐ Wheezing	☐ Increased Sputum
	☐ Shortness of Breath	☐ Snoring	☐ Sleep Apnea/C-PAP
Gastrointestinal	☐ Difficulty Swallowing	☐ 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 Pain	☐ 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/Immunologic	☐ Seasonal	☐ Food	☐ Allergy Shots

Other Comments: _____

Shelley R. Berson, MD, FACS, FAASM, FAAOA • Rockland Ear, Nose and Throat Associates, PC • ZZenter

ID _____ **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 this 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 by checking 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 can be	5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5	☐
2. Nasal Blockage	0	1	2	3	4	5	☐
3. Sneezing	0	1	2	3	4	5	☐
4. Runny nose	0	1	2	3	4	5	☐
5. Cough	0	1	2	3	4	5	☐
6. Post-nasal discharge	0	1	2	3	4	5	☐
7. Thick nasal discharge	0	1	2	3	4	5	☐
8. Ear fullness	0	1	2	3	4	5	☐
9. Dizziness	0	1	2	3	4	5	☐
10. Ear pain	0	1	2	3	4	5	☐
11. Facial pain/pressure	0	1	2	3	4	5	☐
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5	☐
13. Difficulty falling asleep	0	1	2	3	4	5	☐
14. Wake up at night	0	1	2	3	4	5	☐
15. Lack of a good night's sleep	0	1	2	3	4	5	☐
16. Wake up tired	0	1	2	3	4	5	☐
17. Fatigue	0	1	2	3	4	5	☐
18. Reduced productivity	0	1	2	3	4	5	☐
19. Reduced concentration	0	1	2	3	4	5	☐
20. Frustrated/restless/irritable	0	1	2	3	4	5	☐
21. Sad	0	1	2	3	4	5	☐
22. Embarrassed	0	1	2	3	4	5	☐

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

RESET ALL