Name: _____ Todays Date: _____

Why are you here today? _____

Height: _____ Weight: _____

Review of Systems- Place a check if you presently have the following symptoms:

General: ☐ Fever ☐ Chills ☐ Headaches

Eyes: ☐ Blurred vision ☐ Glaucoma

Ears: ☐ Hearing loss ☐ Ear pain ☐ Ringing in the ears ☐ Dizziness ☐ Vertigo

☐ Drainage ☐ Hearing aides ☐ Chronic noise exposure in the past

☐ Chronic noise currently ☐ Clogged ears

Nose: ☐ Bleeding ☐ Difficulty breathing ☐ Stuffiness ☐ Postnasal drip ☐ Snoring

☐ Sleep Apnea ☐ Nasal surgery ☐ Hay fever/allergies ☐ Injuries to nose

☐ Broken nose ☐ Sinus pain ☐ Sinus pressure ☐ Nasal Polyps

Throat: ☐ Soreness ☐ Pain/difficult swallowing ☐ Voice changes ☐ Hoarse

☐ Bad: Taste/breath ☐ Throat clearing

Neck: ☐ Lump ☐ Thyroid nodules ☐ Pain ☐ Swollen glands

Respiratory: ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Asthma ☐ Bronchitis

GI: ☐ Reflux ☐ Heartburn ☐ Nausea ☐ Ulcers ☐ Vomiting ☐ Diarrhea

Endocrine: ☐ Diabetes ☐ Weight loss or gain ☐ Fatigue ☐ Pregnancy ☐ Thyroid problems

Blood/Lymphatics: ☐ Easy bleeding or bruising ☐ Anemia ☐ Swollen glands

Skin: ☐ Unexplained rash ☐ Psoriasis ☐ Skin cancers ☐ Eczema

Cardiovascular: ☐ Chest Pain ☐ Angina ☐ Palpitations

Neurologic/Psych: ☐ Stroke ☐ Weakness ☐ Anxiety ☐ Depression

Musculoskeletal: ☐ TMJ problems ☐ Grinding teeth ☐ Neck arthritis/stiffness

PAST MEDICAL HISTORY:

Place a check if you have had the following illnesses.

- ☐ Allergies (example hayfever)
- ☐ Anemia (low iron)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Back pain
- ☐ Cancer Skin lesions
- ☐ Noncancer skin lesions
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Eye Infections
- ☐ Eye Problems
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High triglycerides
- ☐ Hypertension (high blood pressure)
- ☐ Immune deficiency
- ☐ Kidney problem
- ☐ Lung problems
- ☐ Nose bleeds
- ☐ Panic disorder
- ☐ Skin Problems
- ☐ Stomach problem
- ☐ Thyroid disorder
- ☐ Hearing Loss

Drug Allergies: IF NONE STATE NONE

_____

_____

_____

_____

List Medications - If you have a preprinted list please give it to the front desk:

_____

_____

_____

_____

Smoking Status: ☐ Yes ☐ No ☐ Previous

Ethnicity:

- ☐ Hispanic
- ☐ Non- Hispanic
- ☐ Not Specified

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Other

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

Alcohol: ☐ No Alcohol ☐ Beer ☐ Wine ☐ Hard Liquor ☐ Approximately _____ servings per week

Drugs: ☐ Never Used ☐ Previously ☐ Occasionally ☐ Currently Use _____

Caffeine: ☐ None _____ Servings per day

Diet: ☐ Regular ☐ Diabetic ☐ Heart Healthy ☐ Low Cholesterol ☐ Soft

Pets: ☐ There are pets in the house ☐ There are NO pets in the house

Family History: Please circle if brother/sister, child, or close relative has:

☐ Anesthesia complication ☐ Bleeding disorder ☐ Cancer ☐ Diabetes ☐ Hearing Loss ☐ Heart disease

Hospitalizations/ Operations/Surgery:

Hospitalizations/Surgeries:

_____

_____

_____

Date: _____

PATIENT INFORMATION SHEET

Patient _____ _____ _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone#: _____

Date Of Birth: _____ Age: _____ Social Security #: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by: _____

Address: _____ Phone: _____

Person Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____ SS #: _____

Person Employed By: _____

Employers Address and phone: _____

Primary Medical Insurance _____

ID #: _____ Policy Holders Name: _____ DOB: _____

Secondary Medical Insurance

ID #: _____ Policy Holders Name: _____ DOB: _____

Primary Care Doctor _____ Phone: _____

Who referred you to us: _____

In case of emergency whom may we contact _____ Phone: _____

Pharmacy Name: _____ Phone: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.
I have read, agree and consent to all of the Sunrise ENT P.C. Financial Policies and Protected Health Information Policies posted on their on-line website.

Patient and/or Responsible Party _____ Date: _____

SUNRISE E.N.T. P.C. FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

Please understand that it is your responsibility to know the details of your insurance policy and any co-pays. deductibles and coinsurances that you may be responsible for above and beyond your office co-pay. The doctor may need to perform tests to help diagnose and treat your condition and your insurance company may charge an additional co-pay for these tests. By-law we are unable to reduce or waive these charges.

Patients must fill out patient information forms every visit, prior to seeing the doctor because your insurance company requires us to have documentation for each examination.

We will request to photocopy your insurance card and photo id for your file.

- COPAYMENTS - By law we MUST collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at each visit.
- NON CO-PAY PLANS - If your plan does not require a co-pay and we participate. we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on the explanation of benefits.
- REFERRALS - If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it and have it with you at the time of your visit.
- NON-PLAN PATIENTS - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance fonn and sent to your carrier who will reimburse you directly.
- MEDICARE - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to the secondary insurance if you have one.

  I request that payment of authorized Medicare and Insurance benefits be made on my behalf to Sunrise E.N.T. P.C. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and any information needed to determine these benefits or the benefits payable for related services.

  You are responsible for the timely payment of your account. We accept Cash, Checks. MasterCard. Visa. American Express or Discover

  Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns

Responsible Party Signature: _____ Date: _____

SUNRISE ENT P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby consent to Sunrise ENT P.C. (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone, or other designated location and leaving a message on my voicemail or in-person in reference to any items, and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Healt Information.

_____

Patient's Name (Please Print)

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____ _____ _____

Home Phone Cell Phone Work Phone Fax Number

_____

Email Address

_____

Name and relationship of person you wish to receive your protected health information

SUNRISE ENT P.C.

As per HIPAA rules and regulations, you are required to inform this office how you wish us to communicate with you in regards to your Personal Health Information (PHI). At times we may need to contact you to confirm your appointment,schedule surgery, return your phone calls, or to give you results of labs, x-rays, scans, or consultations. We are required to follow your written instructions specifically, except where we feel following the instruction would be detrimental to your health or in case of emergency. Please be very specific as to how we are to reach you, where we can leave a message, and with whom.

You may change your decision at any time by filing a request for change with our office manager at 100 Sunrise Highway, Lindenhurst, NY 11757 Fax - 631-226-4659

Patient Consent Form

The Department of Health and Human Services has established a ·'Privacy Rule" to help in sure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients ' consent for uses and disclosures of health information about the patient to carry our treatment, payments, or health care operations.

As our patient we want you to known that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we fell are in need of your health care information, information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. WE may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.
Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken. which relied on this or a previously signed consent.

If you have any other objections to this form , please speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Compliance and Assurance Notification for Our Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers. and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the ·' Privac) Rule." We strive to achieve the very highest standards of ethnics and integrity in performing services for our patients.
It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.
We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any though of penalization ifthey feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.