OCEAN OTOLARYNGOLOGY ASSOCIATES

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Toms River, NJ 08753 **Wall, NJ 08736** **Whiting, NJ 08759**

PATIENT DEMOGRAPHIC FORM

Date: _____

First Name: _____ **Last Name:** _____ **M.I.** _____

Date of Birth: _____ **Sex:** _____ **SSN:** _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____ x _____

E-mail address: _____ Do not wish to share e-mail Do not have e-mail

Employment Status: Full-time Part-time Retired Unemployed Other

Student Status: Full-time Part-time Not a student

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ Caucasian/White ☐ Hispanic ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** _____

Responsible Party: ☐ Self ☐ Other: _____

Are you a former patient? ☐ Yes ☐ No Year_____ ☐ Office ☐ Hospital

Emergency Contact: _____ **Relation:** _____

Phone:_____ **Address:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Address: _____ Address:_____

Pharmacy: _____ **Address:** _____ **Phone:** _____

How did you hear about us? ☐Primary Care Physician ☐Other Healthcare Physician ☐Family/Friend

☐ Office Website ☐ Newspaper/Ocean County Women ☐Facebook ☐ Internet ☐Emergency Dept.

☐Insurance Company ☐Other: _____

Insurance Information:

1) _____ ☐ Subscriber ☐ Dependent

ID #: _____ Grp # _____ Copay: _____

2) _____ ☐ Subscriber ☐ Dependent

ID #: _____ Grp # _____ Copay: _____

If Dependent:

Insured's Name: _____ Relationship to subscriber: _____

Address (including city, state, zip): _____

Date of Birth: _____ Phone: _____

I authorize the release of any information related to claims on behalf of myself. I acknowledge that my signature authorizes this office to submit claims for services rendered, and serves as an assignment of benefits to my physician. I further understand that even though the physician's office will submit to my insurance company, the bill is ultimately my responsibility, and I agree to payment in a timely manner. For participating insurance companies, the proper referral or precertification must be presented for complete coverage. ***FAILURE TO OBTAIN A REFERRAL OR PREAUTHORIZATION PRIOR TO THE VISIT WILL RESULT IN PATIENT BEING FINANCIALLY RESPONSIBLE FOR THE VISIT.***

Signature: _____ Date: _____

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NOTICE OF PRIVACY ACTS

This is to certify that I_____ allow my medical information to be released to:

☐ **Family members** (include relation): _____

☐ **Medical Doctors** : _____

OR

I do not wish to have any of my health related information released to anyone other than myself.

PLEASE CHOOSE ONE:

I give permission to leave a message in regards to blood work results, outside testing, appointments, etc. either on my answering machine or with a family member who answers my home telephone.

OR

If I am unable to be reached by phone, no messages pertaining to myself are to be left on my home answering machine or with a family member except for appointment reminders.

Any changes of patient release information must be given in writing.
Verbal requests for changes will not be honored.

Print Name:_____ Initial: _____

PATIENT FOLLOW-UP PLEDGE

I, _____(print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of the doctors should be expected.

Signature: _____ Date: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement about our Financial Policy which we request you read and sign prior to any treatment.

REGARDING INSURANCE:

All copayments are due at time of service. If we are a participating provider with your insurance company, we will be happy to submit your claim. We accept usual and customary rates from the insurance companies; however you will be responsible for any co-pays, co–insurance, or deductibles due to us. If your insurance plan requires you to obtain a referral from your Primary Care Doctor, and if that referral is not given to the office at the time of service, you may be financially responsible for that office visit. In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for the balance at the time of your visit. Regarding Medicare, we do accept assignment. However, if you do not have a supplemental insurance, the 20% co-insurance is your responsibility and due at the time of service. We do not accept Cobra, Workman's Comp., or Auto/Accident Insurance**. As an ears, nose, and throat specialty office, it may be required for the physician to use diagnostic instruments to achieve a treatment plan. You're insurance company may categorize this as a surgical procedure. Based on your insurance and the type of plan you have, this may require us to bill you for this procedure.**

FINANCIAL INTEREST DISCLOSURE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, take notice that practitioners in this office do have a financial interest in the following health care services to which patients are referred:

BEY LEA AMBULATORY SURGICAL CENTER

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

CANCELLATION POLICY

We reserve the right to charge a patient **$25.00** if they do not show for their scheduled appointment, or if a patient cancels less than 24 hours prior to their appointment. We will not charge you this amount in the case of an emergency or work/school related issue. However, after 3 no shows/cancellations, patient will be billed the cancellation fee.

ASSIGNMENT OF BENEFITS:

I hereby authorize assignment and payment of all my medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, directly to Ocean Otolaryngology Associates. I have read the Financial Policy. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature of Responsible Party: _____ Date: _____

Patient Name (print): _____

PATIENT QUESTIONAIRE

Name _____ **Age:** _____ **Date** _____

Past Medical History:
Do you suffer from any of the following?

Diabetes (Problems w/ blood sugar)	[ ]
Congestive Heart Failure	[ ]
Angina (chest pain)	[ ]
Previous heart attack	[ ]
Heart murmur	[ ]
Coronary artery disease	[ ]
High blood pressure	[ ]
High cholesterol	[ ]
Stroke	[ ]
Cancer	[ ]
Seizures	[ ]
Bleeding disorders/Anemia	[ ]
Thyroid disorders	[ ]
Asthma	[ ]
Emphysema	[ ]
Migraine headaches	[ ]
Kidney disorders	[ ]
Gastrointestinal disorders	[ ]
Tuberculosis	[ ]
Sleep apnea	[ ]
Rheumatoid arthritis/Osteoarthritis	[ ]
Back or neck problems	[ ]
Osteoporosis	[ ]
Glaucoma	[ ]
Cataracts	[ ]
Sarcoidosis	[ ]
Hepatitis, cirrhosis, or liver disease	[ ]
Depression	[ ]
Prostate problems	[ ]
Difficulty w/ anesthesia	[ ]
Lupus	[ ]
Rheumatic fever	[ ]

OTHER: _____
_____

Review of Systems:
Do you suffer from any of the following?

Change in appetite / Weight Loss	[ ]
Fatigue/Lethargy	[ ]
Headaches	[ ]
Dizziness/Lightheadedness/ Fainting	[ ]
Blurred Vision	[ ]
Tingling/Numbness	[ ]
Pain	[ ]
Decreased hearing	[ ]
Decreased sense of smell	[ ]
Difficulty swallowing	[ ]
Sore throat	[ ]
Swollen glands	[ ]
Cough	[ ]
Hemoptysis	[ ]
Shortness of breath	
At Rest	[ ]
With Exertion	[ ]
Wheezing	[ ]
Cold intolerance	[ ]
Heat intolerance	[ ]
Excessive thirst	[ ]
Chest pain	
At Rest	[ ]
With Exertion	[ ]
Irregular heart beat	[ ]
Abdominal Pain	[ ]
Nausea/Vomiting	[ ]
Diarrhea	[ ]
Blood in urine	[ ]
Difficulty urinating	[ ]
Frequent urinating	[ ]
Painful joints	[ ]
Dry skin	[ ]
Itchy skin	[ ]
Rashes	[ ]

Past Surgical History:
Please check the box below if you've had:

Tonsillectomy/Adenoidectomy	[ ]
Heart bypass surgery	[ ]
Carotid surgery	[ ]
Appendectomy	[ ]
Gall bladder surgery	[ ]
Ear surgery	[ ]

Other: _____
_____
_____
_____
_____

Medications:

Please list all medications that you currently take:
(If you have a mediation list, please provide a copy)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you currently take:

Garlic [ ]
Gingko Biloba [ ]
Vitamin E [ ]
Aspirin [ ]
Motrin/Ibuprofen/Advil [ ]
Other herbal preparations: _____

Allergies:

Do you have allergies to medications? [ ]
Please Specify: _____
Do you have allergies to X-ray contrast? [ ]
Do you have allergies to:
Hay fever [ ]
Pollen [ ]
Dust [ ]
Mold [ ]
Pets [ ]
Latex [ ]

Social History

Do you now, or have you ever smoked? [ ]
If so, how much do you smoke per day? _____
If you no longer smoke, when did you quit? _____
Do you drink alcohol? [ ]
If so, how much daily or weekly? _____
Do you drink:
Coffee [ ] How much per day? _____
Tea [ ] How much per day? _____
Soda w/ caffeine [ ] How much per day? _____

Family History

Has anyone in your family ever suffered from any of the following?

Heart disease [ ] Who? _____
Cancer [ ] Who? _____
Thyroid disorders [ ] Who? _____
Early onset hearing loss [ ] Who? _____
Diabetes [ ] Who? _____
Bleeding problems [ ] Who? _____
Other: _____

For Office Use Only:
ROS Reviewed [ ]

History Reviewed: _____