

OCEAN OTOLARYNGOLOGY ASSOCIATES

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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: \_\_\_\_\_

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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 **\$50.00** if they do not show for their scheduled appointment, or if a patient cancels less than 24 hours prior to their appointment.

### 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): \_\_\_\_\_

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**PATIENT QUESTIONNAIRE**

**Patients: Please write your height and weight below. Thank you.**

Height \_\_\_\_\_ Weight \_\_\_\_\_

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 [ ]
- Rheumatoidarthritis/Osteoarthritis [ ]
- Back or neck problems [ ]
- Osteoporosis [ ]
- Glaucoma [ ]
- Cataracts [ ]
- Sarcoidosis [ ]
- Hepatitis, cirrhosis, or liver disease [ ]
- Depression [ ]
- Prostate problems [ ]
- Difficulty w/ anesthesia [ ]
- Lupus [ ]
- Rheumatic fever [ ]

***OTHER:*** \_\_\_\_\_  
 \_\_\_\_\_

**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 [ ]

**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 [ ]

**Other:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:**

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

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 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	[ ]
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History Reviewed: \_\_\_\_\_