

OCEAN OTOLARYNGOLOGY LLC

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PATIENT DEMOGRAPHIC FORM

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

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

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Allow text confirmations? _____

Work: _____ X _____

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

DO YOU HAVE A LIVING WILL ? YES/NO

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: _____

INSURANCED SUBSCRIBER NAME: _____ D.O.B. _____

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: _____

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.

I AGREE TO ALLOW THIS HEALTHCARE PROVIDER TO FILE AN APPEAL ON MY BEHALF WITH MY HEALTH PLAN IF THERE IS A QUESTION ABOUT COVERAGE FOR ALL OR ANY SERVICE RENDERED.

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.**

ELECTRONICAL AI MEDICAL RECORDS

At Ocean ENT this office uses the help of AI to generate your electronical medical records. To ensure accuracy, your conversation with the doctor is recorded and intergraded into your visit notes. These recordings are deleted after seven days and are not used in anyway outside of your personal medical record.

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): _____ D.O.B. _____

PATIENT QUESTIONNAIRE

Name _____ D.O.B. _____ Age: _____ Height: _____ Weight: _____ 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:

Name: _____ D.O.B. _____

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: _____