ENT of Denver, PC

Owen Reichman, MD Anya Miller, MD Mallory Sessions, PA-C Fabiola Castro-Lauman, AuD

Date: _____

Patient Information

Patient's Name: First **Middle** **Last**	**Birthdate:**	**Sex:** ☐ M ☐ F

Race

☐ African/Black ☐ Asian ☐ Native American ☐ Pacific Islander ☐ White ☐ Other _____ ☐ Decline to state

Ethnicity

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other _____ ☐ Decline to State

Primary Language

☐ English ☐ Russian ☐ Spanish ☐ Other: _____

Street Address: (Include Unit #)	**PO Box:**	**City:**	**State:**	**ZIP Code:**

Social Security No.:	**Marital Status:**	**Employment Status** ☐ Employed ☐ Retired ☐ Child ☐ Other

Home Phone	**Cell Phone**	**Work Phone**	**Email Address**

Do you consent to electronic communications from our office?	**Written Communication Preference**
☐ Email ☐ Text ☐ Decline Any Electronic Communications	☐ Postal Mail ☐ Email

Additional Providers

Primary Care Physician (Name and Phone if available)	**Referring Provider (Name and Phone if available)**

Billing and Insurance Information

Primary Insurance Carrier:	**Member Identification Number**	**Group Number**

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child	**Subscriber Name**	**Subscriber Date of Birth**

Secondary Insurance Carrier:	**Member Identification Number**	**Group Number**

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child	**Subscriber Name**	**Subscriber Date of Birth**

Who should receive statements and billing/insurance notices?	**Address (if different than above)**

Parent/Guardian Information (Minors Only)

Parent/Guardian Name:	**Birth date:**	**Sex:** ☐ M ☐ F

Street Address: (if different than patient)	**PO Box:**	**City:**	**State:**	**ZIP Code:**

Social Security no.:	**Home phone:**	**Work phone:**	**Cell phone:**

Parent/Guardian Name:	**Birth date:**	**Sex:** ☐ M ☐ F

Street Address: : (if different than patient)	**PO Box:**	**City:**	**State:**	**ZIP Code:**

Social Security no.:	**Home phone:**	**Work phone:**	**Cell phone:**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. This notice describes our treatment, payment activities, healthcare operations, uses, and disclosures we may make of your protected health information and other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure wholly and carefully before signing the consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:
Contact Person: Monica Tye
Telephone: 303-316-7048
Email: monica@entdenver.com
Address: 4500 E. 9th Ave Suite 610, Denver, CO 80220

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. We may decline to treat you or continue treating you if you revoke this consent.

I,_____, (please print) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

HIPAA Approved Contacts: **HOME:** _____ **WORK:**_____ **CELL:**_____

Phone: for all the above numbers:

☐ Do ☐ Do Not leave message on my answering machine
☐ Do ☐ Do Not leave message with any other person

Email: I want you contact me at the following email address_____

Other: Other requests for confidential communications (specify)_____

Please list any family member, personal friend or other third party you give us permission to share your protected health information

Name:	Phone Number	Relationship:

I _____ (print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. By signing this consent, I understand that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient/Guardian Signature:_____ Relationship to Patient:_____ Date:_____

Patient Name: _____ Date of Birth _____

ENT of Denver, PC

Patient Name _____ **Date of Birth** _____ **Date** _____

Pharmacy (Please be sure to include the location *or* phone number) _____

_____ (Initial) **eRx Consent:** The providers at ENT of Denver, PC use an electronic medical record system (EMR) that permits our providers to prescribe medications electronically. By initialing, you agree that ENT of Denver, PC can request and use your prescription medication from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Medications

(Please list all medications and dosages you are currently taking. Including over-the-counter and herbal supplements)

Medication	Dose (required)	Medication	Dose (required)

Medication Allergies

Do you have any allergies to medications? If yes, please list medication and the reaction to it.

Medication	Reaction	Medication	Reaction

Non-Medications Allergies

Have you ever had allergy testing? ☐No ☐Yes

If Yes, what type of testing: ☐ Blood Testing ☐ Skin Testing ☐ Unknown

Where was the testing done? _____ When was testing done? _____

Do you have an allergy to any of the following?

☐Adhesive Tape ☐Animal Hair ☐Bee Sting ☐Eggs ☐Environmental Allergies ☐Grass Pollen ☐House Dust ☐Iodine ☐Latex ☐Mold ☐Peanuts ☐Pollen ☐Ragweed Pollen ☐Shellfish ☐Tree/Shrub Pollen ☐Weed Pollen ☐ Other _____

Past Medical History Have you been diagnosed with any of the following conditions?

☐ *No Significant Medical History*

ALLERGY

☐ Hay Fever
☐ Seasonal Nasal Allergy
☐ History of Anaphylaxis

CANCER

☐ Throat/ Larynx
☐ Thyroid
☐ Tongue
☐ Other Cancer Type: ☐ _____

CARDIOVASCULAR

☐ Elevated Blood Cholesterol
☐ High Blood Pressure
☐ Other Heart Problem: ☐ _____

DIGESTIVE

☐ Colitis
☐ GERD
☐ Hepatitis (A ☐ B☐ C☐)
☐ Liver Disease
☐ Other Digestive Problem: ☐ _____

EARS

☐ Cholesteatoma
☐ Frequent Ear Infections
☐ Hearing Loss
☐ Otosclerosis

ENDOCRINE

☐ Diabetes Type I
☐ Diabetes Type II

ENDOCRINE continue

☐ Hyperthyroidism
☐ Hypothyroidism
☐ Thyroid Nodule

EYES

☐ Dry Eyes
☐ Other Eyes Problem: ☐ _____

GENITOURINARY

☐ Currently Pregnant

HEMATOLOGICAL

☐ Anemia
☐ Clotting Disorder
☐ Hemophilia
☐ Sickle Cell Disease

INFECTIOUS

☐ HIV Positive

MUSCLE, BONES

☐ Arthritis: Type _____
☐ Fibromyalgia

NERVOUS SYSTEM

☐ Headaches/Migraines
☐ Stroke
☐ Traumatic Brian Injury

PSYCHOLOGICAL

☐ Anxiety/Depression

RESPIRATORY

☐ Asthma
☐ COPD

Past Medical History Have you been diagnosed with any of the following conditions?

RESPIRATORY continue

- ☐ Deviated Septum
- ☐ Peritonsillar Abscess
- ☐ Nasal Polyps
- ☐ Sleep Apnea
- ☐ Recurrent Sinusitis
- ☐ Recurrent Tonsillitis
- ☐ Tuberculosis

RHEUMATOLOGIC

- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome

Hospitalizations

Have you ever been hospitalized for a medical problem (non-surgical) ☐ No ☐ Yes

When/Reason for Admission _____

Surgery

Have you ever had any reaction or problem with anesthesia? ☐ No ☐ Yes

What was the reaction? When did it occur? _____

Procedure	Date	Procedure	Date

Family History

☐ No family history of significant health problems ☐ Patient adopted, family history is unknown

	Mother	Father	Brother	Sister
Deceased	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer (indicate type) _____	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

Test and Immunizations

Have you had an Influenza (Flu) Vaccine? ☐ No ☐ Yes When (Month/Year) _____

Have you had the COVID-19 Vaccine? ☐ No ☐ Yes When (Month/Year) 1st Dose _____

2nd Dose _____

Have you had a Pneumococcal Vaccine? ☐ No ☐ Yes When (Month/Year) _____

Have you ever had a Colonoscopy? ☐ No ☐ Yes When (Month/Year)_____

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Patient Name_____ **Date of Birth**_____ **Date:** _____

Social History

Current Tobacco Use:

☐ None ☐ Cigarettes
☐ Smokeless Tobacco ☐ Cigars

When do you start using tobacco? (year)_____

Give the closest amount you smoke/use per day.

☐ ½ pack ☐ 1 pack
☐ 2 packs ☐ 3 packs
☐ Other _____

History of Tobacco Use:

☐ None ☐ Cigarettes
☐ Smokeless Tobacco ☐ Cigars

When did you quit? _____

When did you start smoking? (year)_____

Give the closest amount you smoked/used per day.

☐ ½ pack ☐ 1 pack
☐ 2 packs ☐ 3 packs
☐ Other _____

Occupation _____ ☐ Retired

Alcohol Beverages

A drink is 1 shot of liquor, 1 glass of wine, 1 beer.

☐ None ☐ Social (< 1 month)
☐ Occasional ☐ Light
☐ Heavy (>2/day)

Do you use recreational drugs?

☐ Yes ☐ No

If yes, what type of drug(s)? _____

Do you use marijuana?

☐ Medicinally ☐ Recreationally ☐ No

If you use marijuana, how often?

☐ Daily ☐ Occasional

Other _____

If marijuana used, how do you consume it?

☐ Edible (oral ingestions) ☐ Smoking
☐ Vaping Other_____

Caffeine Use (servings per day)

☐ None ☐ 1 per day
☐ 2-3 per day ☐ 4 or more per day

Home Living Situation (mark all that apply)

☐ Alone ☐ With spouse
☐ With children ☐ With mother
☐ With father ☐ Siblings
☐ Nursing home ☐ Lives in assisted living
☐ Other _____

Assistive Medical Devices/Needs

☐ Legally Blind ☐ Uses Hearing Aid
☐ Uses Wheelchair ☐ Walker
☐ Supplemental Oxygen
☐ Other _____

Review of Systems

Do you have or have you recently had any of the following symptoms?

General Health
- ☐ Excessive Daytime Tiredness
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia
- ☐ Other Sleeping Problems
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eyeglass Use
- ☐ Itchy Eyes
- ☐ Pain In Eye(S)
- ☐ Uncorrectable Vision
- ☐ Watery Eye(S)

Ears
- ☐ Dizziness
- ☐ Drainage
- ☐ Hearing Loss
- ☐ Infection
- ☐ Itchy Ears
- ☐ Ear Pain
- ☐ Pressure In the Ears
- ☐ Ringing In the Ears

Nose
- ☐ Facial Pressure
- ☐ Mouth Breathing
- ☐ Nasal Congestion
- ☐ Nasal Itching
- ☐ Nosebleeds
- ☐ Postnasal Drainage
- ☐ Runny Nose

Mouth
- ☐ Change in Dentition
- ☐ Dry Mouth
- ☐ Sores In the Mouth
- ☐ Tongue Irritation

Throat/Neck
- ☐ Frequent Throat Clearing
- ☐ Hoarseness Or Voice Change
- ☐ Lump in the neck
- ☐ Tenderness in the neck
- ☐ Sensation Of Something Caught in The Throat
- ☐ Snoring
- ☐ Tonsils Enlarged

Respiratory
- ☐ Productive Cough
- ☐ Non-Productive Cough
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Shortness of Breathing
  - ☐ w/exertion
  - ☐ Lying Flat
  - ☐ During Sleep
- ☐ Swelling Of Ankles/Legs

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Coughing After Swallowing
- ☐ Heartburn/Indigestion
- ☐ Nausea
- ☐ Swallowing, Difficulty
- ☐ Swallowing, Painful
- ☐ Vomiting

Musculoskeletal
- ☐ Painful Joints
- ☐ Stiffness In Joints
- ☐ Swelling In Joints

Neurological
- ☐ Blackouts
- ☐ Change In Smell
- ☐ Change In Taste
- ☐ Headache

Endocrine
- ☐ Cold Intolerance
- ☐ Increased Appetite
- ☐ Feels Cold

Hematology/Lymphatic
- ☐ Bleeds Easily
- ☐ Bruises Easily
- ☐ Masses (Lumps), Armpit
- ☐ Masses (Lumps), Neck

Allergic, Infectious
- ☐ Hives
- ☐ Seasonal Rhinitis
- ☐ Sneezing

ENT of Denver, PC

Patient Name_____ **Date of Birth**_____ **Date:** _____

Height _____ **Weight** _____

History of Present Illness

Chief Complaint Please describe the main reason or symptom(s) for your visit today.

_____

Present Illness Please describe the history of illness/symptoms that has caused you to seek care with us.

_____

How long have the symptoms been present? _____

Is there a time of day or season of the year when the symptoms are worse? _____

Is this a recurrent problem? ☐ No ☐ Yes When was the first episode? _____

Have there been any changes in duration or frequency of episodes? _____

What were the circumstances when your problems first occurred (i.e. bad cold, injury, etc?) _____

What makes the symptoms better? (i.e. rest, home remedies, movement, etc.)_____

What makes the symptoms worse? (i.e. environment, activity, etc.) _____

Have any diagnostic tests been performed (please list when and where completed)?_____

_____

What treatments have you had so far? Was there any improvement with them? Any adverse reaction?

_____

APPOINTMENT SCHEDULING POLICIES

MISSED/NO SHOW POLICY

Our goal is to provide quality care promptly. To do so, we have had to implement a "No Show" appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care

As a courtesy and to help patients remember their scheduled appointments, ENT of Denver sends a text message and email reminder in advance of the appointment time. We phone patients the day before their appointment to confirm. If your schedule changes and you cannot keep your appointment, please contact us to reschedule you and accommodate those patients waiting for an appointment.

As a courtesy to our office and patients waiting to schedule with the provider, please give us at least 24-hour notice. **If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a $100 fee "no-show" service charge to your account.** This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of ENT of Denver and agree to provide a credit card number, which may be charged $100 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment no later than 3:00 pm on the business day in advance of my appointment to avoid a potential no-show charge to the credit card provided.

Definition of "No Show" Appointment
ENT of Denver defines a "no show" appointment as any scheduled appointment in which the patient either:

- Does not show
- Cancelation with less than 24-hour notice
- Arriving more than 15 minutes late to their appointment and is consequently unable to be seen.

CANCELLATION/DATE CHANGE OF SURGICAL PROCEDURE

_____Patients who cancel scheduled surgery appointment within 1 or 2 weeks shall be subject to a "Cancellation fee" of $250.00 non-refundable to reschedule surgery appointment. This "cancellation fee" is not reimbursable by your insurance company.

LATE ARRIVAL POLICY

Please call us if you do not think you will be on time for your visit. We have a 15-minute grace period for your appointment; if you arrive beyond that time, it is up to the provider's discretion if you will need to reschedule.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient Name Date of Birth

FINANCIAL POLICY

Financial Policy:
To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please feel free to discuss them with the billing staff. We pride ourselves on providing the best possible care and service to you and your family. We think that your complete understanding of our financial policies is an essential element of your care and treatment.

Unless arranged in advance, full payment for office services is due at the time of service. For your convenience, we accept: VISA, MasterCard, Discover, and American Express, as well as cash, check, or money order.

About Health Insurance:

_____Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive payment from your insurer, we will refund any overpayment to you.

About Participating Health Plans and Coverage:

_____ (Initial) We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment or anticipated out-of-pocket expense.

_____ (Initial) All health plans are not the same and do not cover the same services. If your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of the statement from our office.

_____ (Initial) We will look to the adult accompanying a minor patient for payment for all services rendered to minor patients.

Coverage for Diagnostic Services:

_____ (Initial) Any procedure or testing performed during your office visit often will incur additional out-of-pocket expenses beyond your office visit copayment.

_____(Initial) Many insurance carriers apply procedures and diagnostic testing to your deductible and coinsurance. If your surgical deductible has not been met, the allowable charge per your insurance company contract will be applied to the patient's responsibility. Procedures and testing that often result in additional patient cost includes:

- Laryngoscopy (examination of the vocal cords with fiberoptic scope)
- Nasal endoscopy (examination inside the nose with fiberoptic scope)
- Nasal cautery/packing placement or removal
- Audiogram, hearing aid services
- CT Scan of the Sinuses

By signing below, I acknowledge that I have read and understood the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient Name Date of Birth