



PEDIATRIC & ADULT OTOLARYNGOLOGY • HEAD & NECK SURGERY

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**YOU MUST BRING WITH YOU:**

- \_\_\_ **Completed** paperwork in this packet
- \_\_\_ Insurance Cards + Co-pay
- \_\_\_ If you have blood test results, CT, x-ray reports (**ACTUAL CD/Disc (CT/MRI)**) related to this visit, it is your responsibility to obtain these results
- \_\_\_ **Current Medication List**

**Radiology Department Contact Numbers:**

- Reading Hospital 484-628-4444
- St. Joseph Hospital 610-378-2247
- Diagnostic Health 610-478-8797
- Surgical Institute of Reading 610-378-8800

Dear \_\_\_\_\_:

Welcome to our practice! This will confirm the appointment that has been made for you. **PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.**

**If you had a recent CT scan, sleep study, MRI, x-rays or lab work related to your visit, we request that YOU pick up the CD/Disc plus the report and bring this with you the day of your visit.** Any reports that your primary care physician can fax to us prior to your visit, will again be helpful. These reports are an essential part of your medical history and are critical to efficient delivery of care.

Many insurance plans require a referral. Please check with your insurance carrier if a referral is required. If so, please contact your primary care physician. **Please be sure you have obtained all the proper insurance referrals prior to your appointment. Co-payments are due at the time of service.**

**New patients are asked to arrive 15 minutes prior to your appointment with all paperwork completed before you arrive to the office.**

Please arrive at \_\_\_\_\_.

Your appointment time(s) are: \_\_\_\_\_ at \_\_\_\_\_ AM/PM  
\_\_\_\_\_ at \_\_\_\_\_ AM/PM

- Patients arriving 15 minutes late or more, arriving without the actual CD/Disc, reports or referrals may be asked to reschedule
- Patients under the age of 18 must be accompanied by a parent or legal guardian.
- Appointments must be cancelled 24 hours prior to scheduled appointments. A fee of \$35 will be charged for cancellations, changes and no shows.

We look forward to having you as our patient. If you have any questions prior to your appointment, please do not hesitate to contact our office at 610-374-5599.

10-10-16 revision

**PATIENT INFORMATION SHEET (ADULT)**

**Acct:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male or Female

Referring Doctor: \_\_\_\_\_

Social Security: \_\_\_\_\_

Referring Doctor Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

\_\_\_\_\_

Family Doctor Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

People authorized to receive medical information

Work Phone: \_\_\_\_\_

(Name and Number) \_\_\_\_\_

Cell Phone: \_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_

\_\_\_\_\_

**Have you or any family member been seen at our office before? YES-NO If yes, who?** \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ Co-Pay Amount\$ \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Address of subscriber (if different than above) \_\_\_\_\_

Social Security # of subscriber: \_\_\_\_\_ (Required) Date of Birth: \_\_\_\_\_

Employer of subscriber: \_\_\_\_\_

Employer's address: \_\_\_\_\_

\_\_\_\_\_ Employer's Phone: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Co-Pay Amount\$ \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Address of subscriber (if different than above) \_\_\_\_\_

Social Security # of subscriber: \_\_\_\_\_ (Required) Date of Birth: \_\_\_\_\_

Employer of subscriber: \_\_\_\_\_

Employer's address: \_\_\_\_\_

\_\_\_\_\_ Employer's Phone: \_\_\_\_\_

**HIPAA:** I have read and agree with the HIPAA Privacy information.

**Financial Policy:** I have read and understand the financial policy.

**Insurance Authorization/Assignment**

I hereby authorize ENT Head & Neck Specialists to release and/or obtain information to/from insurance carriers, other physicians, and/or medical facilities concerning my present illness/treatment and past medical history/treatment. I also hereby assign to the physicians of ENT Head & Neck Specialists all payments for medical services rendered to myself. I understand that I am responsible for any amount not covered by my insurance.

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE NOTE:** Our office is not responsible for charges incurred if updated insurance information is not provided by the patient.

**PATIENT MEDICAL HISTORY**

**TODAY'S DATE:** \_\_\_\_\_ Acct: \_\_\_\_\_ Page 1/2

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_\_ Marital status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic/Latino \_\_\_ Other \_\_\_

Preferred Language: English \_\_\_ Spanish \_\_\_ Other \_\_\_ **EMAIL:** \_\_\_\_\_

**What is the reason for your visit?** \_\_\_\_\_

Prior Testing For this Condition: YES / NO If Yes, please indicate the date of the test and what tests were performed? \_\_\_\_\_

Approximate date started: \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Who is your Family Doctor? \_\_\_\_\_

**Pharmacy/Address:** \_\_\_\_\_

**PATIENT MEDICATION LIST**

**Please list all the medications (prescription & non-prescription) that you are currently taking, including Vitamins**

Medication	Strength (mg)	Time per Day	Medication	Strength (mg)	Times per Day

**Are you allergic to any medication?** YES / NO If Yes, please list all medication allergies and the TYPE OF REACTION: \_\_\_\_\_

Have you had allergy testing? YES / NO Date: \_\_\_\_\_ Skin? YES/NO Blood? YES/NO

Treated with allergy shots? YES / NO

**List all food, contact and inhalant allergies:** \_\_\_\_\_

**PATIENT PAST MEDICAL HISTORY**

Do you have any of the following? YES / NO If yes, please CHECK the appropriate medical condition(s).

- |                    |                          |                                    |                         |
|--------------------|--------------------------|------------------------------------|-------------------------|
| ___ Diabetes I     | ___ Diabetes II          | ___ High Cholesterol               | ___ High Blood Pressure |
| ___ Asthma         | ___ Tuberculosis History | ___ Sleep Apnea                    | ___ Nasal allergies     |
| ___ Depression     | ___ Anxiety              | ___ History of Kidney Stones       |                         |
| ___ Thyroid nodule | ___ Thyroid dysfunction  | ___ History of stomach ulcer       |                         |
| ___ Reflux (GERD)  | ___ Bleeding Disorder    | ___ Hepatitis: Type: _____         |                         |
| ___ HIV            | ___ AIDS                 | ___ History of Cancer: Type: _____ |                         |
|                    |                          | Year Diagnosed: _____              |                         |

Is there a chance you are currently pregnant: \_\_\_ Yes \_\_\_ No \_\_\_ N/A

Other medical conditions or problems: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

Have you or anyone in your family been seen by one of our physicians in the past? YES/NO If yes, please remind us of that person's name and the physician he or she saw.

Have you had a colonoscopy?      \_\_\_ Yes \_\_\_ No      If Yes, month \_\_\_\_\_ year \_\_\_\_\_  
 Have you had a pneumonia vaccination?      \_\_\_ Yes \_\_\_ No      If Yes, month \_\_\_\_\_ year \_\_\_\_\_  
 Have you had an influenza (flu) vaccination:      \_\_\_ Yes \_\_\_ No      If Yes, month \_\_\_\_\_ year \_\_\_\_\_  
 Have you had a mammogram?      \_\_\_ Yes \_\_\_ No      If Yes, month \_\_\_\_\_ year \_\_\_\_\_  
 Have you had a pap screening?      \_\_\_ Yes \_\_\_ No      If Yes, month \_\_\_\_\_ year \_\_\_\_\_

Year	Surgical Procedure/Reason for Hospitalization	Reason

Have you had any serious injuries, such as head trauma, broken bones, concussion, or loss of consciousness?      YES / NO  
 If Yes, please give the date and type of injury: \_\_\_\_\_

Do you or any member of your family have a history of problems with anesthesia?      YES / NO  
 If Yes, please explain: \_\_\_\_\_

**FAMILY HISTORY (Has any family member had any of the following: Heart Disease, Diabetes, Bleeding Disorders/problems, High Cholesterol, Allergies, Stroke, Asthma, High Blood Pressure, Hearing Loss, Cancer & what type?)**

Type	Family Member

**Social History**

Do you smoke? YES / NO    If yes, amount/day: \_\_\_\_\_    Number of years: \_\_\_\_\_  
 If you have smoked in the past, when did you quit? \_\_\_\_\_    How much did you smoke a day? \_\_\_\_\_

Do you consume alcohol? YES / NO    If Yes, please indicate amount and frequency: \_\_\_\_\_  
 Is there a personal history of substance abuse? YES / NO    If Yes, please explain: \_\_\_\_\_

If the patient is a minor, is he or she exposed to cigarette smoke?    YES / NO

**Do you CURRENTLY have any of the following? YES / NO Please CHECK the medical symptom(s).**

- |                                     |                        |                     |                           |
|-------------------------------------|------------------------|---------------------|---------------------------|
| ___ Blurred vision                  | ___ Double vision      | ___ Ear drainage    | ___ Hearing loss          |
| ___ Dizziness                       | ___ Ringing in ears    | ___ Ear pain        | ___ Nasal congestion      |
| ___ Nosebleeds                      | ___ Postnasal drainage | ___ Facial pressure | ___ Sore throats          |
| ___ Hoarseness                      | ___ Snoring            | ___ Chest pain      | ___ Irregular heart beat  |
| ___ Cough                           | ___ Wheezing           | ___ Neck Mass       | ___ Shortness of breath   |
| ___ Stomach pain                    | ___ Nausea             | ___ Headaches       | ___ Benign skin lesion    |
| ___ Vomiting                        | ___ Diarrhea           | ___ Seizures        | ___ Malignant skin lesion |
| ___ Chills                          | ___ Sweats             | ___ Memory Loss     | ___ Sudden Weight Change  |
| ___ Difficulty or painful urinating |                        |                     |                           |

Is there a personal history of hearing loss? YES / NO    If yes, when was the last time your hearing was evaluated? \_\_\_\_\_  
 Where? \_\_\_\_\_

Do you wear Hearing Aid(s)? YES / NO    How old are your current aid(s)? \_\_\_\_\_

**ENT HEAD & NECK SPECIALISTS, PC**  
**985 Berkshire Boulevard, Suite 101**  
**Wyomissing, PA 19610**  
**(610) 374-5599**

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**FINANCIAL POLICY**

In the interest of good practice, we believe that it is desirable to establish a financial policy for our patients. Our goal is to avoid any miscommunication or concerns regarding financial matters, so that we may focus our energies on serving the healthcare needs of our patients. Please ask our staff if you have any questions about this. We appreciate the opportunity to participate in your health care.

- Patients are responsible for payment of all medical treatment and services provided.
  - Insurance co-pays shall be collected before being seen for each office visit.
  - Insurance co-pays and deductibles for elective surgery shall be collected prior to surgery.
  - Patients are responsible for notifying our office if you have a pre-existing clause with your insurance (this usually applies to insurance effective dates of less than 12 to 18 months).
  
- Our office participates with and accepts assignment with many insurance carriers.
  - As a service to our patients, we will file insurance claims for all covered services.
  - As a participating provider in a network, we will accept the insurance company's allowable payment for covered services.
  - Patients are responsible for deductibles, co-payments, non-covered services, and out-of-network services. Payment for these shall be due at the time of the visit.
  - Many health plans require a referral to be seen in our office. If this applies to your plan, you are responsible for providing our office with the appropriate authorization or referral from your primary care physician prior to your appointment.
  - Patients will not be seen without a referral if required by their insurance carrier, and may be asked to reschedule.
  - Current primary and secondary insurance cards are needed at each visit; otherwise we will need payment in full at the time of your visit.
  - Patients must advise us of the need for pre-certification by their insurance for any services.
  - Insurance plans sometimes request the patient to complete a coordination of benefits questionnaire. If requested, please complete this form and return it to your carrier. Your insurance may deny your claim if not received, and you would be responsible for payment of services in full.
  
- A \$35 fee shall be charged for all returned checks.
  
- If you have a past due balance, you will be required to make payment on this prior to being seen. It is our policy that when an account is referred to our collection agency, we will terminate any future medical care until the account is satisfied.
  
- **Appointments must be cancelled 24 hours prior to scheduled appointments. A fee of \$35 will be charged for cancellations, changes or no shows.**

Should you have any questions regarding the above, please contact our office manager. We will always be willing to discuss your insurance and/or a payment plan best suited for all concerned.

The following methods of payment are acceptable: CASH, PERSONAL CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER. FINANCING IS ALSO AVAILABLE THROUGH CARE CREDIT.

**From the West (Lebanon, Sinking Spring, West Lawn)**

Take Route 422 East to the Crossing Drive exit. Turn left at the bottom of the ramp onto Crossing Drive. You will pass Olive Garden on your left and Best Buy on your right, as you go through the first traffic light. At the second traffic light (Home Depot on your right), you will make a left onto Berkshire Blvd. Make an immediate right into the Wyomissing Professional Center. At the stop sign, bear left. Our building will be on the right, sitting adjacent to Papermill Road, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

**From the East (Exeter, Pottstown)**

Take route 422 West to the Papermill Road exit. Go straight through the first traffic light (the Tokyo Hibachi Restaurant is on your right at the corner). At the second light (Hampton Inn on the left), go straight. Take the next right driveway into the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

**From the North (Kutztown, Blandon)**

Take route 222 South to the Broadcasting Road exit. Turn right at the bottom of the ramp onto Broadcasting Road. Go straight through the first traffic light (the Barnes & Noble store, and Wawa are on the right). At the second light, turn left onto Papermill Road. Go straight through the 1<sup>st</sup> traffic light (Stone Hill Farms condominiums on the left), and immediately after the light, turn left into the driveway for the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

**From the South (Morgantown Area)**

Follow I-176 North/Morgantown Expressway. Take exit 11B toward Reading, and merge onto US-422 West. (at the fork in the highway, stay to the left for US-422, not the right - Rt 12). Take route 422 West to the Papermill Road exit. Go straight through the first traffic light (the Tokyo Hibachi Restaurant is on your right at the corner). At the second light (Hampton Inn on the left), go straight. Take the next right driveway into the Wyomissing Professional Center. Our building is immediately on the left, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.

**From the Southwest (Lancaster Area)**

Follow US-222 North toward Ephrata/Reading. Continue on US-222 (It merges with US422 East at this point) just past the Berkshire Mall on your left, and take the Crossing Drive exit. Turn left at the bottom of the ramp onto Crossing Drive. You will pass Olive Garden on your left and Best Buy on your right, as you go through the first traffic light. At the second traffic light (Home Depot on your right), you will make a left onto Berkshire Blvd. Make an immediate right into the Wyomissing Professional Center. At the stop sign, bear left. Our building will be on the right, sitting adjacent to Papermill Road, #985. Enter through the front door, our suite number is 101, straight down the hallway from the front entrance.