CT EAR NOSE THROAT ASSOCIATES

ACCOUNT NO. _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

S.S.N.: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Pharmacy Name: _____ Phone: _____ Location: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____

Relationship: _____ Phone: _____

Referring Doctor

Name: _____

Address: _____

Phone: _____

Primary Insurance Information

Insurance Name: _____

Primary Cardholder: _____

Relationship: _____

Birth Date: _____ SSN: _____

Identification Number: _____

Group Policy Number: _____

Primary Care Doctor

Name: _____

Address: _____

Phone: _____

Secondary Insurance Information

Insurance Name: _____

Primary Cardholder: _____

Relationship: _____

Birth Date: _____ SSN: _____

Identification Number: _____

Group Policy Number: _____

Employer Information (of Subscriber)

Employer: _____

Address: _____

City: _____

State: _____

Phone: _____

Workers Compensation: ☐ Yes ☐ No

If yes, please indicate below the date and how you were injured on the job:

Have you reported this injury to your employer? ☐ Yes ☐ No

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Connecticut Ear, Nose & Throat Associates, P.C. all surgical and/or medical benefits, if any. (This includes, but is not limited to, Medicare, Commercial Carriers and any applicable Managed Health Care organizations). I understand that I am financially responsible for charges not covered by this assignment and agree to bear any reasonable cost of collection including court costs and attorney's fees should this be required.

_____ _____

Date Signed (Patient or Parent if Minor)

CONNECTICUT Ear Nose & Throat CONNECTICUT

Financial & Office Policies

Thank you for choosing us as your healthcare provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating our expectations and options for payment.

Registration & Check-In

I understand that copays and past due balances are due at the time of check-in and I will come prepared to pay or be charged an **additional $10 for processing.** I will also bring my current insurance card and drivers license to each visit to ensure my claims are sent to the appropriate insurance company and to protect my identity. I understand that if I arrive 15 minutes late for my appointment, I may be asked to reschedule so that other patients are not inconvenienced. **I also understand that I will be charged a fee of $50 if I no show for my appointment or cancel without giving 24 hours notice.**

Insurance Billing

Though Connecticut Ear Nose & Throat Assoc., P.C. accepts most insurance plans; I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals

If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

Self Pay

If I am un-insured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

Patient Billing

I understand that I will be sent a **single** monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. **If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collections attorney. If my account is referred to a collections attorney, I may be dismissed from the practice and will be responsible for any reasonable cost of collection including credit checks, court costs and attorney's fees.** If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of $25.00.

Surgical and Office Procedures

I understand that my insurance company may not cover the entire cost of procedures rendered in the office or in the operating room. If it is determined that there will be a significant out of pocket expense for my procedure, I understand that I will be asked to either make a pre-payment or schedule of payments using Connecticut Ear Nose & Throat Assoc., P.C.'s *card on file* system. I understand that my credit card or checking information will be secured by the office.

I have read, understood and agree to abide by the terms stated in the above financial and office policy.

Patient Name _____ Patient (or Parent/Guardian) Signature _____

Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Connecticut Ear, Nose & Throat Associates, P.C. (CT ENT)
85 Seymour Street, Hartford, CT 06106
Toni A. Patterson, Privacy Officer (860)493-1950

Name of Patient:_____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for Refusal:

_____

_____

CONNECTICUT Ear Nose & Throat CONNECTICUT

Chief Complaint and History of Present Illness

1. Please briefly describe the problem that brings you here today.

2. Please list any treatment or tests you have already received for this problem.

3. Please list all the medicine you are currently taking.

4. Please list any known allergies to drugs, food, inhalants or other substance.

5. Are you pregnant? ☐ Yes ☐ No ☐ Possibly

CONNECTICUT Ear Nose & Throat CONNECTICUT

Review of Systems

Please check the box next to any medical condition that you ***currently*** have

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue

Endocrine
- ☐ Weight loss
- ☐ Weight gain
- ☐ Intolerance to Heat
- ☐ Intolerance to Cold

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up blood

Musculoskeletal
- ☐ Muscle aches
- ☐ Bone pain

Skin
- ☐ Rashes
- ☐ Itching
- ☐ Sores
- ☐ Skin Changes

Lymphatic/Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding

Psychiatric
- ☐ Anxiety
- ☐ Depression

Eye
- ☐ Blurred Vision
- ☐ Itchy eyes
- ☐ Double vision
- ☐ Eye pain
- ☐ Dryness
- ☐ Tearing

Gastrointestinal
- ☐ Constipation
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Belching

Neurologic
- ☐ Seizures
- ☐ Headache

Allergic/Immunologic
- ☐ Sneezing
- ☐ Seasonal allergies

Ear, Nose & Throat
- ☐ Hearing loss
- ☐ Noise in ears
- ☐ Ear discharge
- ☐ Earache
- ☐ Itchy ears
- ☐ Dizziness
- ☐ Ear lesions
- ☐ Loss of Sense of smell
- ☐ Nosebleeds
- ☐ Nasal discharge
- ☐ Nasal congestion
- ☐ Post-nasal drip
- ☐ Nasal lesions/polyps
- ☐ Bleeding gums
- ☐ Oral sores
- ☐ Dry mouth
- ☐ Bad breath
- ☐ Loss of sense of taste
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Problems swallowing
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Lumps in neck
- ☐ Unclear speech
- ☐ Sinus infections

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Stroke

CONNECTICUT Ear Nose & Throat CONNECTICUT

Past Medical, Family and Social History

1. Please check the box next to any medical condition that you currently have or have had in the past

☐ Asthma	☐ G.I. Disease	☐ Thyroid Disease
☐ Kidney Disease	☐ Depression	☐ HIV/AIDS
☐ Cancer	☐ High Blood Pressure	☐ E.N.T. Surgery
☐ Diabetes	☐ Heart Disease	☐ Anemia
☐ Hepatitis	☐ Liver Disease/Jaundice	☐ Hemophilia
☐ Stroke	☐ Chemical dependency	☐ STI/STD

☐ Bleeding Tendency/ Bleeding Disorder (easy bleeding or bruising)
☐ Other_____

2. Please list any previous surgeries.
_____
_____

3. Do you have any medical restrictions due to your religion? ☐ Yes ☐ No

4. Is there a family history of hearing loss or vertigo problems? ☐ Yes ☐ No

5. Is there a family history of bleeding disorder? ☐ Yes ☐ No

6. If yes, please list the name of the disorder_____

7. Have you ever smoked cigarettes, cigars, pipes or chewed tobacco?
☐ Yes ☐ No

8. Do you smoke now? ☐ Yes ☐ No

9. If you have stopped, how old were you when you stopped?
_____

10. On average, how many packs per day have you smoked for the length of time you smoked?_____

11. How many packs per day do you smoke now?

12. Do you drink alcoholic beverages? ☐ Yes ☐ No

13. If so, how often do you consume alcoholic beverages?

☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times per week ☐ 4 or more times a week

14. How many alcoholic drinks do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more

HARTFORD HOSPITAL
80 Seymour Street P.O. Box 5037
Hartford, CT 06102-5037

166015

Hearing and Balance Center
65 Memorial Rd., Suite 200, West Hartford, CT 06117
860/545-4478 Phone • 860/496-1961 Fax

Dizziness Questionnaire for the Hartford Hospital Balance Clinic

Name:_____ Date:_____

1. Is the dizziness you are experiencing better characterized as a spinning, a light-headedness, or unsteadiness?	❒ Yes ❒ No
2. Is the dizziness you are experiencing a continuous symptom or does it come in episodes?	❒ Continuous symptom or ❒ Episodes
3. If it comes in episodes, do the episodes last for: *(select one)* ❒ Seconds ❒ Minutes ❒ Hours ❒ Days	
4. When you have episodes, do you experience ringing in the ears, fullness in the ears, or changes in your hearing?	❒ Yes ❒ No
5. Is there nausea or vomiting associated with your dizziness?	❒ Yes ❒ No
6. Is there anything you can do to bring on your dizziness?	❒ Yes ❒ No
7. Does lying down in bed make you dizzy?	❒ Yes ❒ No
8. Does looking up or looking down make you dizzy?	❒ Yes ❒ No
9. Is there anything you can do to improve your dizziness when it is occurring? If yes, what? _____	❒ Yes ❒ No
10. Have you ever fallen?	❒ Yes ❒ No
11. Have you taken medications for dizziness? If so, what? _____	❒ Yes ❒ No
12. Does the medication help?	❒ Yes ❒ No
13. Is your dizziness associated with changes in vision, weakness, or clumsiness in the arms or legs?	❒ Yes ❒ No
14. Do you have a history of migraine headaches?	❒ Yes ❒ No

Mailing Address: Marc D. Eisen, M.D., Ph.D., 85 Seymour Street, Suite 318, Hartford, CT 06106

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