

**WE ASK THAT PAYMENT BE MADE AT THE TIME OF EACH OFFICE VISIT
WE ACCEPT THE FOLLOWING: MASTERCARD, VISA, CASH OR CHECK**

PATIENT NAME _____ SEX _____ AGE _____ BIRTH DATE _____

ADDRESS _____ SOC. SECURITY # _____
Number and Street Apt # City State Zip

HOME PHONE # _____ CELL PHONE # _____

PATIENT'S EMPLOYER _____
Name Work Phone

NAME OF PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT) _____

ADDRESS & PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER AND PHONE _____

NAME AND PHONE # OF NEAREST RELATIVE OR FRIEND _____

NAME OF FAMILY MEMBER PREVIOUSLY SEEN IN OUR OFFICE: _____ DATE _____

IF PATIENT IS UNDER 18 YEARS OF AGE:

FATHER'S NAME _____ SOC. SECURITY # _____

EMPLOYER _____ WORK PHONE _____

MOTHER'S NAME _____ SOC. SECURITY # _____

EMPLOYER _____ WORK PHONE _____

Who referred you to us? _____

Who is your Primary Care Physician? _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY # _____

Insured's Name _____ SSN: _____

Insured's Date of Birth _____ Insurance Co. Phone # _____ GROUP # _____

SECONDARY INSURANCE _____ POLICY # _____

Insured's Name _____ SSN: _____

Insured's Date of Birth _____ Insurance Co. Phone # _____ GROUP # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

- 1) I authorize Arthur Torsiglieri, MD, Donald Cote, MD, and/or Ronald Shashy, MD to release to my insurance carriers any information requested concerning my examination or treatment, and I understand that I am responsible for any charges not covered by my insurance.
- 2) I hereby authorize payment directly to Arthur Torsiglieri, MD, Donald Cote, MD, and/or Ronald Shashy, MD for surgical and medical benefits payable for the services performed.
- 3) I authorize the administration of any anesthetics and analgesics (eardrops and medication) that the doctor / PA advises.
- 4) I understand that a reasonable fee will be added each month to accounts over 120 days old.
- 5) My signature below indicates that I am aware of ENT Specialists, LLC's Privacy Policy and it's availability for my review.
- 6) I authorize ENT Specialists staff to contact me AND/OR leave a message at: home work

SIGNATURE OF PATIENT OR GUARDIAN

PRINTED NAME OF GUARDIAN

DATE

Ear, Nose & Throat Specialists, LLC Patient History

Name: _____

Briefly describe reason for visit: _____

Symptoms for how long? _____

Prior treatment for this problem: _____

Have you ever been diagnosed or treated with any of the following: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Nasal Surgery | <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Nasal Trauma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart valve problem |
| <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> CAT scan sinus or head | | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sleep Study | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Daily ASPIRIN use | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Anesthesia Reaction |

Current Medications: (include aspirin, blood thinners, vitamins, herbal, birth control)

List all **Surgeries:** _____

Allergies : (include allergies to medication, contrast or dyes, latex, iodine)

Smoker? 1) If Yes → Packs per day _____ # of years? _____ 2) Quit _____ What Year? _____
3) Never smoked _____ 4) Snuff or Chewing Tobacco _____ 5) Cigar or Pipe _____

Do you drink beer, wine or liquor on a daily basis? Yes _____ No _____

Patient Signature

Date