303-792-3242 **Advanced ENT & Allergy Center** AdvancedENTdenver.com

Demographic and Contact Information

Name: _____ Birth Date: _____
As on Drivers License First Last Middle Initial

Address: _____
Street & Unit # City State Zip

Home Phone: (____) ____ - _____ Cell: (____) ____ - _____ Email: _____

Any Restrictions for Contacting You? No ☐ Yes ☐ Details: _____

SS # _____ Gender: Male ☐ Female ☐ Employer: _____

Marital Status: Single ☐ Married ☐ Spouse Name: _____

Insurance Information

Primary Insurance Company: _____

Secondary Insurance Company (if applicable): _____

- Please fill out if policy holder is different than patient

Policy Holder: _____ Birthdate: _____
First Last Middle Initial

Address: _____
Street & Unit # City State Zip

SS # _____ Gender: Male ☐ Female ☐ Employer: _____

Emergency Contact

Emergency Contact/ Relationship: _____/_____ Phone # (____) ____ - _____

How Did You Hear About Us?

☐ Web Search ☐ Physician Name: _____

☐ Mailing ☐ Friend/ Family Name: _____

Privacy Policy

In the process of providing medical care, Advanced ENT & Allergy Center collects and retains personal information concerning our patients. Advanced ENT & Allergy Center respects the privacy of your personal information and appreciates the importance of protecting this information by keeping it confidential and stored in a secure manner. Please note that some communication including email, text and other forms of electronic communication may not be secure. For more information, please visit our website.

I understand and agree to the Advanced ENT & Allergy Center Privacy Policy **Initial:** _____

Verification

By signing, I attest that all information provided is accurate and current to the best of my knowledge.

Signature _____ Date _____

Financial Policy Agreement

At the Advanced ENT & Allergy Center we are committed to making our patients everyday lives better. There are always ongoing changes in the healthcare industry and these changes may affect you and the services that are covered by your insurance carrier. This following form is designed to help you fully understand our financial policies and we require every patient to read and sign prior to any treatment.

- Payment is due at the time of service unless arrangements have been made in advance or you have insurance coverage. We accept all major credit cards, cash and checks. If paying by check, you will be responsible for any processing fees that are incurred from a dishonored check.
- A **Cancellation Fee** of at least **$35** will be charged on all missed appointments as well as appointments cancelled with less than 24 hours' notice. Longer appointments may be subject to a higher cancellation fee. Due to the office closing at noon on Fridays, Monday appointments must be cancelled no later than 10:00AM on Friday morning.
- Please keep in mind that an insurance policy is a contract between you and your insurance company. As the patient, you are ultimately responsible for payment for all services rendered. As a service to our patients, we file your insurance claim and the insurance company pays us directly. Due to the complexity of the insurance industry, we are unable to know each carriers reimbursements and what procedures apply to your deductible and what does not. Please bring your card to every appointment and contact your insurance company directly with any questions regarding coverage.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Your financial responsibility to our office will be your co-payment (if any), the amount your insurance company deems your responsibility (deductibles and co-insurance), and denials for services not covered by your policy. Payment is due upon receipt of a bill from our office.
- After exhausting our internal attempts for payment, we will send all delinquent accounts to a collection agency. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay delinquent account in full before scheduling another appointment.

Endoscopy Billing Information

Please be advised that there are times when a provider needs to perform an in-office procedure to correctly diagnose and treat problems of the nose and throat. This is accomplished with the use of a **Nasal Endoscope.** A Nasal Endoscopy is a quick and painless in-office procedure. After spraying your nasal passages to anesthetize the lining and shrink tissue, a thin tube or endoscope is then inserted into the nasal passage to visualize the internal anatomy of the nose, sinuses and/ or throat.

Insurance companies always consider endoscopies a surgical procedure. We do not have control over how endoscopies are processed by insurance companies. This form is to notify you in advance so you are not surprised when you receive your Explanation of Benefits that states a "Surgical Service" was provided.

Your insurance company may reimburse a surgical service at a different rate than an office visit. The nasal endoscopy procedure is often applied toward your deductible and co-insurance. To find out what your financial responsibility may be, contact your insurance carrier and request coverage information for CPT codes 31231 and 31575.

_____

I have read and accept the terms and conditions of the Financial Policy and Endoscopy Billing Information

Patient or Legal
Guardian Signature: _____

Print Name: _____ Date: _____

Advanced ENT & Allergy Center

Health and Social History

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Pharmacy: _____ Cross Streets: _____

Personal and Family Medical History

Please indicate if you or a family member have ever been diagnosed with any of the following conditions. For each box marked please provide details, including which family member affected.

	Self	Family	Details
No Medical History	☐	☐	
Food Allergies	☐	☐	
Nasal Allergies	☐	☐	
Asthma/ Lung Disease	☐	☐	
Autoimmune Disease	☐	☐	
Bleeding Disorders (Clotting/ Anemia)	☐	☐	
Bone/ Joint/ TMJ	☐	☐	
Cancer	☐	☐	
Chest Pain/ Tightness	☐	☐	
Cold Sores	☐	☐	
Diabetes	☐	☐	
Easy Bruising	☐	☐	
Glaucoma	☐	☐	
Headaches/ Migraines	☐	☐	
Hearing Loss	☐	☐	
Heart Disease/ Heart Attack	☐	☐	
Heart Murmur	☐	☐	
Hepatitis/ Liver Disorder	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
HIV	☐	☐	
Nasal Trauma	☐	☐	
Nosebleeds	☐	☐	
Anesthesia Problems	☐	☐	
Reflux/ Heartburn	☐	☐	
Sinus Infections	☐	☐	
Skin Disease/ Rash	☐	☐	
Sleep Apnea/ Snoring	☐	☐	
Stroke	☐	☐	
Thyroid Disorder	☐	☐	
Tinnitus/ Ringing in Ears	☐	☐	
Chemical Dependency	☐	☐	

Social History

Patient Height: _____ ft. _____ in Patient Weight: _____ lbs

Alcohol Consumption: Never Drink ☐ Occasional ☐ Daily ☐ # of drinks per week _____

Tobacco Use: I Have Never Smoked or Chewed Tobacco ☐ (skip next 3 lines if checked)

Former Smoker ☐ Year Quit _____ Years Smoked _____ Packs/Day _____

Current Smoker ☐ Years Smoked _____ Packs/ day _____

Chewing Tobacco: Former ☐ Current ☐

Marijuana Use: Never ☐ Former ☐ Occasional ☐ Daily ☐

Other Recreational Drug Use: Never ☐ Former ☐ Current ☐ Type(s) _____

Currently Breastfeeding or Pregnant? Yes ☐ No ☐

Race: African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other ☐ Decline ☐

Ethnicity: _____ Language preferred: _____

Ability to Heal

Does your skin appear fragile or burn easily? Yes ☐ No ☐

Do you form thick or raised scarring from a cut or burn? Yes ☐ No ☐

Surgical History (If None Mark N/A)

Operation	Year	Details/ Complications
1.		
2.		
3.		
4.		

Allergies - Please list all Medication, Food and Latex Allergies (If None Mark N/A)

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Current Medications (If None Mark N/A)

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		

Verification

By signing , I attest that all information provided is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____