



Patient Name:				DOB:	
Have You Ever Had:	YES	NO	Are you being seen for a cosmetic consultation:		
High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Complete this section ONLY if answer is YES	YES	NO
Irregular Heartbeat/Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Do you plan to gain or lose more than 10 lbs?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Angina/Mitral Valve Prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	Current wt _____; Weight 1 year ago _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Respiratory Disease?	<input type="checkbox"/>	<input type="checkbox"/>	How long have you been thinking about having plastic surgery?		
Tuberculosis (TB)?	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis/Joint Disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had plastic surgery before?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Liver Disease?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, what was done? When?		
Stomach Trouble (including Ulcers)?	<input type="checkbox"/>	<input type="checkbox"/>	Were you happy with the results?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	Eye disease, including glaucoma or “dry eyes”?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood Disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
AIDS/HIV+?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any other surgery to your head, face or neck?	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety/Panic Attacks?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you currently under psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	How do you think plastic surgery will benefit you?		
Ever had an injury to your head, face or neck?	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer (including skin cancer)? Site:	<input type="checkbox"/>	<input type="checkbox"/>	Do you think plastic surgery will significantly change your life?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had Chemotherapy or Radiation?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you Smoke? How Much?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, in what way?		
Drink Alcohol? How much?	<input type="checkbox"/>	<input type="checkbox"/>	Which of the following are you interested in improving?		
Require treatment for Hay Fever or other Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nose		
			<input type="checkbox"/> Breathing	<input type="checkbox"/> Appearance	
Difficulty Breathing through your nose? Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chin	<input type="checkbox"/> Hair	
			<input type="checkbox"/> Eyelids	<input type="checkbox"/> Ears	
Frequent Nosebleeds? Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Scars		
Any skin disease? (cold sores, herpes, eczema, psoriasis, acne, fever blisters, dermatitis?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acne	<input type="checkbox"/> Other	
			<input type="checkbox"/> Forehead/Brow	<input type="checkbox"/> Wrinkles	
Allergic to adhesive tape, iodine or any cosmetics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Face (Facelift)	<input type="checkbox"/> Facial blemish (i.e.mole)	
			<input type="checkbox"/> Cheek, Lips	<input type="checkbox"/> Other	
Ever received local anesthesia from doctor/dentist?	<input type="checkbox"/>	<input type="checkbox"/>	Please list all your current medications, including dose. <i>(remember to include aspirin, Advil, birth control pills and hormones, steroids, heart and asthma medications, blood thinners, antidepressants and vitamins.)</i>		
Have an adverse reaction?	<input type="checkbox"/>	<input type="checkbox"/>			
WOMEN: Do you suspect you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Last menstrual period:	<input type="checkbox"/>	<input type="checkbox"/>			
Please explain any YES answers:					
			Describe allergic reactions to medications you may have had:		
List any other medical problems/serious illness you may have:			<input type="checkbox"/> Penicillin	<input type="checkbox"/> Amoxicillin/Augmentin	
			<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Cipro	
List all prior surgery:			<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Local Anesthetic	
			<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	
X			<input type="checkbox"/> Other		
Patient Signature	Date		<input type="checkbox"/> To my knowledge, I have NEVER had an allergic reaction to any medications both prescribed and over the counter.		



Date:	Office:	Primary Language Spoken:	
Name:			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Check One: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Race:	Ethnicity:	Advanced Directives: <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOB:	Social Security#:		
Responsible Party:		Relationship:	Phone:
Patient Address:			
Permanent Address (If different):			
Home Telephone:		Cell:	
Email:			
Employed by:		Occupation:	
Business Address:		Phone:	
Emergency Contact:		Relationship:	Phone:
Allergies to Medications:			
Referred By:		Reason for Visit:	
Check one: Illness/ Injury Related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other			Date of Incident:
INSURANCE INFORMATION			
Primary Insurance Company:		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	
Policy/ID#	Group #		
Policy Holder:	Relationship:		
Policy Holder DOB:	Social Security#:		
SECONDARY Insurance Company:		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	
Policy/ID#	Group #		
Policy Holder:	Relationship:		
Policy Holder DOB:	Social Security#:		



NASAL FUNCTION QUESTIONNAIRE

Please check the appropriate box for the following five questions related to your breathing.

	Not a Problem (0)	Very Mild Problem (1)	Moderate Problem (2)	Fairly Bad Problem (3)	Severe Problem (4)
Nasal Congestion or Stiffness					
Nasal Blockage or Obstruction					
Trouble Breathing Through My Nose					
Trouble Sleeping					
Unable to Get Enough Air Through My Nose During Exercise or Exertion					

Raw

Final



COSMETIC CONSULTATION FORM

The cosmetic consultation fee is \$200, payable on the day of your visit. For surgical procedures performed in an operating room facility, the cosmetic consultation fee will be applied to the cost of the procedure. This does not apply to office procedures.

AUTHORIZATION: I authorize treatment of the individual named as patient. I understand that Dr. Sclafani or his agents will file with my primary insurance for services rendered and I authorize payment of medical insurance benefits to be made directly to my treating physician, Anthony P. Sclafani, MD. I also understand that I am financially responsible for any service that is not covered under the terms of my insurance policy. I understand that for any procedure(s) deemed a. medically necessary, b. cosmetic, or c. not covered under the terms of my policy, I am will be financially responsible for payment in full and will be billed accordingly.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing.

I authorize Dr. Sclafani or his agents to release or obtain any medical information related to the treatment of the patient. A photocopy of this authorization shall be considered as effective and valid as the original. I agree that all photocopies of this form may be used in lieu of the original. I fully understand and agree to comply with this policy.

Patient Name: _____

(Print)

Signature: _____

(Patient or Responsible Party)

Date: _____



REFERRING PHYSICIAN, MEDICATION AND PHARMACY INFORMATION FORM

Patient's Name:	Date:
Name and Address of Internist or Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	Fax:

MEDICATIONS

Do you have any allergies to medications? No Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

MEDICATIONS	DOSAGE (mg, teaspoon, etc)	FREQUENCY

VACCINATION HISTORY

Date of most recent Flu Shot (ages 6 mos +)	Date of most recent Pneumonia Shot (ages 65+)
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PHARMACY INFORMATION

In order to expedite prescription service, if required, we would like to have your pharmacy information on file

Pharmacy Name:
Address
Telephone: Fax:
Patient's Signature:



OTOLARYNGOLOGY (ENT)

PAYMENT POLICY FOR IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

- **Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**
- **Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**
- **Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**
- **Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.**
- **Cerumen removal: Removal of wax from the ear canals.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name:

(Print)

Signature:

(Patient or Responsible Party)

Date:



Financial Policy

Welcome to the Department of Otolaryngology-Head & Neck Surgery.

The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the physician you are seeing.

Participating Plans

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

Non-Participating Plans

In this scenario the physician you will see does not participate in your insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Medicare

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office.

Signature of Patient or Responsible Party

Date