



## NEW PATIENT PAPERWORK

Welcome to the practice!

View Your Medical Records Online  
Get visit summaries, health tips & more, all on our website & Patient Portal.  
**[www.NationalSinus.com](http://www.NationalSinus.com)**

**\*\*\*THIS FORM CAN BE ELECTRONICALLY FILLED OUT\*\*\***  
**When opened with the latest version of Adobe Acrobat.**

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

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

Email: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

How did you hear about us?

- ☐ TV ☐ Radio ☐ Provider Referral  
☐ Word of Mouth ☐ Movie Theater ☐ Print Ads  
☐ Facebook ☐ Web ☐ Other

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Legally Separated

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- Race: ☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander  
☐ Asian ☐ African American  
☐ White ☐ Hispanic

Ethnicity: ☐ Hispanic or Latin  
☐ Not Hispanic or Latin

### MEDICAL INSURANCE INFORMATION

**Primary** Insurance Company: \_\_\_\_\_

Policy Number (ID Number): \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Secondary** Insurance Company: \_\_\_\_\_

Policy Number (ID Number): \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



## COMMUNICATION & MESSAGING

I give permission for the National Sinus Institute to leave messages on the answering machine / voice mail / text messaging / email provided by me on this form.

I additionally give the following people permission to receive information from the National Sinus Institute on my behalf:

Name of Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Me: \_\_\_\_\_

Name of Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Me: \_\_\_\_\_

## CONSENT FOR TREATMENT

I certify that the information that I have provided on these forms is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examinations by medical providers.

## NOTICE OF PRIVACY PRACTICES

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our payment activities and healthcare options, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available at the reception desk. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting us at [info@nationalsinus.com](mailto:info@nationalsinus.com)

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed about. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating if you revoke this consent.

## FINANCIAL POLICY

National Sinus Institute PLLC, is committed to providing you with high quality medical care in the most cost effective manner possible. In order to accomplish this, we depend upon your prompt payment for the services we provide.

Co-pays, when applicable, must be paid at the time of the appointment. Payment for all services must be paid or arranged for at the time of the visit. We will offer a discount for bills paid in full at the time of service.

Insurance cards and a valid photo ID must be presented at every visit. Patients are responsible for knowing their insurance benefits, including what services are covered, whether providers are in-network or out-of-network, and whether referrals and authorizations are current and valid. Please note that a prior authorization is not a guarantee of coverage.

Patients will be liable for all non-covered services. Patients will be liable for any service provided that insurance will not pay for.

If you must cancel an appointment, please call 24 hours in advance. Appointments cancelled without 24 hours' notice or not attended are subject to a \$50 fee.

If you must cancel a surgical procedure, please call 72 hours (3 days) in advance. Surgical procedures cancelled without 72 hours' notice or not attended are subject to a \$100 fee.

\*A complete ENT exam may require the use of fiberoptic endoscope, ear cleaning or other minor procedures for which there may be a deductible and/or co-insurance separate from the office visit fee.\*

Your signature is required to be seen at National Sinus Institute. Signing is an agreement to abide by the above policies. If you have any questions, please bring them to our attention before signing.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Parent or guardian if patient is under 18)

Today's Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_



## MEDICATIONS CURRENTLY BEING TAKEN

	Name of Medication?	Dosage / Frequency	Reason / Purpose
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

## MEDICAL HISTORY

Check "Yes" or "No" to indicate whether you have ever been diagnosed with the following.

Allergy Problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Issues / Apnea	Y <input type="checkbox"/> N <input type="checkbox"/>
Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Thyroid Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Bleeding Disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Pace Maker	Y <input type="checkbox"/> N <input type="checkbox"/>
GERD	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>	Chronic Lung Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
HIV/AIDS	Y <input type="checkbox"/> N <input type="checkbox"/>	Hearing Loss	Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>
Anesthesia Difficulty	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Congestion	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Infection	Y <input type="checkbox"/> N <input type="checkbox"/>

Have you fallen in the last 12 months? Y ☐ N ☐

Other medical diagnosis: \_\_\_\_\_

## DRUG/MEDICAL ALLERGIES

Do you have any known drug allergies? ☐ Y ☐ N

If yes, name of medication:

_____	<input type="checkbox"/> Skin Rash/Hives	<input type="checkbox"/> Anaphlaxis	<input type="checkbox"/> Fever	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Skin Rash/Hives	<input type="checkbox"/> Anaphlaxis	<input type="checkbox"/> Fever	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Skin Rash/Hives	<input type="checkbox"/> Anaphlaxis	<input type="checkbox"/> Fever	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Skin Rash/Hives	<input type="checkbox"/> Anaphlaxis	<input type="checkbox"/> Fever	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Skin Rash/Hives	<input type="checkbox"/> Anaphlaxis	<input type="checkbox"/> Fever	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other _____

Are you allergic to latex? ☐ Y ☐ N

Are you allergic to medical tape? ☐ Y ☐ N

## SURGERY HISTORY (INCLUDING TONSILS AND ADENOIDS) AND HOSPITALIZATION

Type of Surgery	Date of Surgery	Type of Surgery	Date of Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

No Surgical History ☐



## FAMILY MEDICAL HISTORY

If "Yes", please indicate which relative has the illness.

### Which Relative?

(Mom, Uncle, Sister, Etc.)

Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

### Which Relative?

(Mom, Uncle, Sister, Etc.)

Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Allergy/Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Anesthesia Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Sinus Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

## SOCIAL HISTORY

Do you currently smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how much? _____
Did you smoke in the past?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how long / how much? _____
Do you drink caffeinated beverages?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many per day? _____
Do you use recreational drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how often? _____
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how often? _____

## PATIENT INFORMATION

What problems are you here for today? \_\_\_\_\_

## TODAY'S SYMPTOMS

Check "Yes" or "No" to indicate whether you PRESENTLY HAVE any of the following.

Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Throat Clearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N	Sweating at Night	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Vocal Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight Gain	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear Drainage	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Aches	<input type="checkbox"/> Y <input type="checkbox"/> N
Daytime Sleepiness	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear Noises	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscle Aches	<input type="checkbox"/> Y <input type="checkbox"/> N
Sneezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear Ringing	<input type="checkbox"/> Y <input type="checkbox"/> N	Passing Out	<input type="checkbox"/> Y <input type="checkbox"/> N
Environmental Allergy	<input type="checkbox"/> Y <input type="checkbox"/> N	Headache	<input type="checkbox"/> Y <input type="checkbox"/> N	Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
Post-Nasal Drip	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N
Ear Fullness	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Tingling	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Snoring	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety or Panic	<input type="checkbox"/> Y <input type="checkbox"/> N
Coughing Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Throat Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye Pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Throat Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N	Watery or Itchy Eyes	<input type="checkbox"/> Y <input type="checkbox"/> N
Feel Warmer Than Others	<input type="checkbox"/> Y <input type="checkbox"/> N	Throat Itching	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Feel Cooler Than Others	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Itching	<input type="checkbox"/> Y <input type="checkbox"/> N
Ear Pain or Itch	<input type="checkbox"/> Y <input type="checkbox"/> N	Upset Stomach	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin or Hair Changes	<input type="checkbox"/> Y <input type="checkbox"/> N
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Imbalance or Woozy	<input type="checkbox"/> Y <input type="checkbox"/> N
Nasal Congestion	<input type="checkbox"/> Y <input type="checkbox"/> N	Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent Head Trauma	<input type="checkbox"/> Y <input type="checkbox"/> N
Sense of Smell Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Glands	<input type="checkbox"/> Y <input type="checkbox"/> N		