Revised 2022

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

*****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: _____

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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

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 $250 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 ☐ N ☐	Diabetes	Y ☐ N ☐	Sleep Issues / Apnea	Y ☐ N ☐
Hypertension	Y ☐ N ☐	Hepatitis	Y ☐ N ☐	Heart Disease	Y ☐ N ☐
Thyroid Disease	Y ☐ N ☐	Bleeding Disorder	Y ☐ N ☐	Pace Maker	Y ☐ N ☐
GERD	Y ☐ N ☐	Cancer	Y ☐ N ☐	Chronic Lung Disease	Y ☐ N ☐
HIV/AIDS	Y ☐ N ☐	Hearing Loss	Y ☐ N ☐	Asthma	Y ☐ N ☐
Anesthesia Difficulty	Y ☐ N ☐	Sinus Congestion	Y ☐ N ☐	Sinus Infection	Y ☐ N ☐

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:

________________ ☐ Skin Rash/Hives ☐ Anaphlaxis ☐ Fever ☐ Digestive Problems ☐ Other ________
________________ ☐ Skin Rash/Hives ☐ Anaphlaxis ☐ Fever ☐ Digestive Problems ☐ Other ________
________________ ☐ Skin Rash/Hives ☐ Anaphlaxis ☐ Fever ☐ Digestive Problems ☐ Other ________
________________ ☐ Skin Rash/Hives ☐ Anaphlaxis ☐ Fever ☐ Digestive Problems ☐ Other ________
________________ ☐ Skin Rash/Hives ☐ Anaphlaxis ☐ Fever ☐ Digestive Problems ☐ 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 ☐

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FAMILY MEDICAL HISTORY

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

		Which Relative? (Mom, Uncle, Sister, Etc.)			Which Relative? (Mom, Uncle, Sister, Etc.)
Heart Disease	☐ Y ☐ N		Bleeding Disorders	☐ Y ☐ N	
Thyroid Disease	☐ Y ☐ N		Allergy/Eczema	☐ Y ☐ N	
Diabetes	☐ Y ☐ N		Arthritis	☐ Y ☐ N	
Cancer	☐ Y ☐ N		Anesthesia Problems	☐ Y ☐ N	
Hearing Loss	☐ Y ☐ N		Sinus Problems	☐ Y ☐ N	

SOCIAL HISTORY

Do you currently smoke?	☐ Y ☐ N	If yes, how much? _____
Did you smoke in the past?	☐ Y ☐ N	If yes, how long / how much? _____
Do you drink caffeinated beverages?	☐ Y ☐ N	If yes, how many per day? _____
Do you use recreational drugs?	☐ Y ☐ N	If yes, how often? _____
Do you drink alcohol?	☐ Y ☐ 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	☐ Y ☐ N	Throat Clearing	☐ Y ☐ N	Bleeding Problems	☐ Y ☐ N
Fatigue	☐ Y ☐ N	Hoarseness	☐ Y ☐ N	Sweating at Night	☐ Y ☐ N
Weight Loss	☐ Y ☐ N	Vocal Problems	☐ Y ☐ N	Easy Bruising	☐ Y ☐ N
Weight Gain	☐ Y ☐ N	Ear Drainage	☐ Y ☐ N	Joint Aches	☐ Y ☐ N
Daytime Sleepiness	☐ Y ☐ N	Ear Noises	☐ Y ☐ N	Muscle Aches	☐ Y ☐ N
Sneezing	☐ Y ☐ N	Ear Ringing	☐ Y ☐ N	Passing Out	☐ Y ☐ N
Environmental Allergy	☐ Y ☐ N	Headache	☐ Y ☐ N	Weakness	☐ Y ☐ N
Post-Nasal Drip	☐ Y ☐ N	Sinus Pressure	☐ Y ☐ N	Numbness	☐ Y ☐ N
Ear Fullness	☐ Y ☐ N	Sinus Pain	☐ Y ☐ N	Tingling	☐ Y ☐ N
Cough	☐ Y ☐ N	Snoring	☐ Y ☐ N	Depression	☐ Y ☐ N
Wheezing	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N	Anxiety or Panic	☐ Y ☐ N
Coughing Blood	☐ Y ☐ N	Throat Pain	☐ Y ☐ N	Eye Pain	☐ Y ☐ N
Shortness of Breath	☐ Y ☐ N	Throat Dryness	☐ Y ☐ N	Watery or Itchy Eyes	☐ Y ☐ N
Feel Warmer Than Others	☐ Y ☐ N	Throat Itching	☐ Y ☐ N	Rash	☐ Y ☐ N
Feel Cooler Than Others	☐ Y ☐ N	Difficulty Swallowing	☐ Y ☐ N	Itching	☐ Y ☐ N
Ear Pain or Itch	☐ Y ☐ N	Upset Stomach	☐ Y ☐ N	Hives	☐ Y ☐ N
Hearing Loss	☐ Y ☐ N	Heartburn	☐ Y ☐ N	Skin or Hair Changes	☐ Y ☐ N
Dizziness	☐ Y ☐ N	Chest Pain	☐ Y ☐ N	Imbalance or Woozy	☐ Y ☐ N
Nasal Congestion	☐ Y ☐ N	Palpitations	☐ Y ☐ N	Recent Head Trauma	☐ Y ☐ N
Sense of Smell Problem	☐ Y ☐ N	Swollen Glands	☐ Y ☐ N		