VALLEY ENT ASSOCIATES, P.C.

Patient Last Name: ______________________________ First Name: _______________________________ Middle Init: ____________________

Date of Birth: ____________________Gender: _________ Race: _________________ Social Security #: __________________________________

Street Address: ___________________________________City: ____________________ State: ________________Zip: _________________________

Phone Number: ___________________________Alternate Phone: _______________________ Email: ____________________________________

Parent / Guardian Name: _______________________Parent / Guardian Address: ____

Emergency Contact: ________________________________Emergency Contact Phone #: ____

Family Physician Name: ________________________________Family Physician Fax #: ____

Referring Physician (If different from above): ________________________Referring Physician Fax # _____________________________

Please list any other physicians and their fax # you would like to have information from today and future visits sent to:

____

Your pharmacy name and location:____

Primary Insurance: __________________ Policy Number: _____________________________ Group Number: ____________________________

Secondary Insurance: __________________ Policy Number: _____________________________ Group Number: ___________________________

Subscriber Name (Primary Insurance): ____ Subscriber Date of Birth: _________________

Subscriber Name (Secondary Insurance): ____ Subscriber Date of Birth: _________________

You will receive a reminder call for your appointments.
Do we have permission to talk about care to a family member? _____

If yes, family member's name: ____ Phone: ___________________________________

BY SIGNING THIS FORM, YOU GIVE OUR DOCTORS PERMISSION TO PERFORM ANY NECESSARY TESTS IN THE OFFICE THAT HE OR SHE SEES FIT AT THE TIME OF SERVICE. TESTS INCLUDE BUT ARE NOT LIMITED TO FLEXIBLE SCOPES, MYRINGOTOMY, FINE NEEDLE BIOPSY, ETC. ☐ Accept ☐Refuse

1. I authorize all medical information to be released to the Insurance Company and payment to be made to Valley Ear, Nose & Throat Associates, P.C.
2. I understand payments (i.e. copayments) are due at the time services are rendered unless prior arrangements have been made.
3. I understand that if I have a Master Medical policy, I am responsible for payments at the time services are rendered.
4. I understand that it is my responsibility to obtain an **INSURANCE REFERRAL FOR EACH VISIT** if I am a member of an **HMO.**
5. I understand that Medicare will not pay for any procedure that is determined to be cosmetic and therefore payment is my responsibility. Consider this my "ONE TIME AUTHORIZATION AGREEMENT" to permit payment of Medicare benefits to Valley Ear, Nose & Throat Associates P.C.
6. I understand that if the provider's charge exceeds the insurance payment, or if my insurance company denies payment, I will be responsible for the amount.
7. I acknowledge that I have received a copy of this office's Notice of Privacy Practices, which includes medical identity theft.

____ _______________________________

Signature of Patient, Parent or Legal Guardian Date

By signing, I acknowledge that I have read all of the above statements.

PLEASE FILL OUT THE NEXT PAGE

PLEASE ATTACH ADDITIONAL SHEETS AS NECESSARY

Name: ____

Date: ____

Reason for visit: _____________________________________

____

WHAT CURRENT COMPLAINTS DO YOU HAVE?

☐ Nasal obstruction/blockage
☐ Pain or pressure over the sinuses
☐ Loss of sense of smell
☐ Nosebleeds
☐ Runny / drippy nose

☐ Sore throats
☐ Difficulty swallowing
☐ Burning tongue
☐ Loss of or change in taste
☐ Hoarseness or change in voice
☐ Coughing up or spitting up blood
☐ Chronic cough
☐ Heartburn

☐ Snoring
☐ Difficulty sleeping
☐ Daytime sleepiness
☐ Recent weight gain
☐ Recent weight loss

☐ Hearing loss
☐ Ear pain
☐ Ringing or buzzing in the ears
☐ Itchy ears
☐ Dizziness or vertigo
☐ Drainage from the ears/Ear infections
☐ Fullness in the ears

☐ Dry mouth
☐ Swelling of the face or neck
☐ Neck mass/lump

DO YOU HAVE OR USE ANY OF THE FOLLOWING?

☐ Hearing Aid(s)
☐ Left ☐ Right
☐ CPAP / BiPAP
☐ Oxygen

What is your **height**: __________

What is your **weight**: __________

HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH

YOU	**PARENT(S)\SIBLING(S)**
☐ Arthritis	☐ Arthritis
☐ Allergies	☐ Allergies
☐ Asthma	☐ Asthma
☐ Anemia	☐ Anemia
☐ Bleeding disorder	☐ Bleeding disorder
☐ Malignant hyperthermia	☐ Malignant hyperthermia
☐ Acid reflux disease/ Heartburn	☐ Acid reflux disease/ Heartburn
☐ Diabetic	☐ Diabetic
☐ Hyper/hypo thyroid	☐ Hyper/hypothyroid
☐ Heart attack	☐ Heart attack
☐ High blood pressure	☐ High blood pressure
☐ Stroke	☐ Stroke
☐ Hepatitis	☐ Hepatitis
☐ HIV/AIDS/TB	☐ HIV/AIDS/TB
☐ COPD/Emphysema	☐ COPD/Emphysema
☐ Sleep apnea	☐ Sleep apnea
☐ Kidney disease	☐ Kidney disease
☐ Cancer	☐ Cancer

Please list type of cancer: ____________________________________

____

Please list any other personal medical conditions:

____

____

____

DO YOU

☐ Use tobacco? (circle one) cigarettes, pipe, chewing tobacco
If so, how much: ______________________
If you quit, how long ago: ________________
☐ Drink alcohol?
If so, how much: ______________________
☐ Use recreational drugs?
If so, what type: ______________________

PLEASE LIST ANY SURGERIES YOU HAVE HAD

____

____

____

<u>MEDICATION</u>

NAME: ______________________________ DATE: ____________________

D.O.B.: ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

If you are not taking any medications, please write "No Medications"

____
____
____
____
____
____
____
____
____
____
____

PLEASE LIST ALL MEDICATIONS YOU ARE <u>ALLERGIC</u> TO

If you are not allergic to any medications, please write "No Medications"

____
____
____
____
____
____
____
____

Do you have an allergy to latex ☐Yes ☐ No

Valley Ear, Nose and Throat Associates, P.C.

New Patient Insurance Information
Saginaw Patients
(989) 799-8620

If you have any of the following insurances:

Blue Care Network

Health Plus of Michigan (not PPO)

Molina (out of network)

<u>You must obtain written authorization and an authorization number from your primary care physician prior to your appointment.</u> If you do not have a required authorization you will either have to reschedule your appointment or pay the required fee before seeing the doctor.

At the time of your appointment we require you to have a photo ID and all current insurance cards to present to the front desk receptionist. If you do not have these items your appointment will be rescheduled.

All co-payments are due at the time of service unless prior arrangements have been made with our billing department. **If you do not have office visit coverage with your insurance we will collect $50.00 at the time of service.** We will bill your insurance and send you a statement for the remainder of the balance.

We require a 24 hour notice for all appointment cancellations. If you do not give a 24 hour notice to cancel your appointment or if you "No Show" for your appointment you will be charged $50.00. If you "No Show" as a new patient you will also be discharged from our practice.

If you have any questions or want to contact our billing department to discuss payment arrangements please call (989) 799-1599.

Thank you for your cooperation.

Valley ENT Associates, P.C.

Valley Ear, Nose and Throat Associates, P.C.

New Patient Insurance Information
All Patients
(989) 799-8620

To determine a correct diagnosis and treatment plan based on your specific concerns, it may be necessary to administer **Hearing**, **Auditory Brainstem Response** (ABR) and/or **Electronystagmography** (ENG) testing when you have any of the following complaints:

- **Hearing Loss/Plugged Ears**
- **Tinnitus (noise in the ears)**
- **Vertigo/Dizziness/Balance Problems**

These tests are often covered by your insurance company. To determine coverage, please call the customer service number located on your insurance card. Below are the procedure and diagnosis codes you may need.

Procedure Codes:	**Diagnosis Codes:**
Audiogram: 92557	**H90.3**
ABR: 92585	**H93.13**
ENG: 92540, 92537 or 92538, 92547	**H81.43**

Thank You

Valley ENT Associates, P.C.