Neal M. Lofchy, M.D. Joseph P. Allegretti, M.D. Jay M. Dutton, M.D.

University Head and Neck Associates

THE MIDWEST SINUS CENTER

Dear Patient:

Thank you for scheduling an appointment with our group. Enclosed is some pre-appointment paperwork for you to complete. It is important that you bring this completed paperwork with you to your visit.

Please note: All copays are collected at the time of service before you see the physician. For your convenience, we accept cash, check, MasterCard, Visa and Discover.

Please bring with you to your appointment the following items:

Photo ID
Insurance Card(s)
Referral Form, if you have an HMO
List of all Medications
Copies of your most recent CT/MRI

Thank you and we look forward to seeing you soon!

Rush Professional Building
1725 W. Harrison Street, Suite 340
Chicago, IL. 60612
(312) 563-9805

Oak Brook Center
120 Oak Brook Center, Suite 508
Oak Brook, IL. 60523
(630) 574-8222

Tinley Park
18210 S. LaGrange Rd., Suite 206
Tinley Park, IL. 60487
(708) 444-1530

MIDWEST SINUS CENTER - UNIVERSITY HEAD & NECK ASSOCIATES
PATIENT INFORMATION [ ]NEW [ ]UPDATE

LAST NAME: _____ FIRST NAME: _____ M. I.: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ GENDER: _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ MARITAL STATUS _____ BUSINESS PHONE # _____
EMPLOYER _____ OCCUPATION _____ ALTERNATE PHONE # _____
SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ BUSINESS PHONE # _____

INSURANCE HOLDERS INFORMATION

PRIMARY INSURANCE

INSURED'S NAME _____
INSURANCE I.D. OR POLICY # _____
GROUP # _____
PHONE # TO VERIFY _____

SECONDARY INSURANCE

INSURED'S NAME _____
INSURANCE I.D. OR POLICY # _____
GROUP # _____
PHONE # TO VERIFY _____

EMERGENCY INFORMATION (IN THE EVENT OF AN EMERGENCY PLEASE NOTIFY)

NAME _____ RELATIONSHIP _____
ADDRESS _____ HOME PHONE _____
BUSINESS PHONE # _____ ALTERNATE PHONE # _____

HOW WERE YOU REFERRED OR HOW DID YOU FIND OUR PRACTICE?

[ ] HMO/PPO [ ] YELLOW PAGES [ ]INTERNET [ ] TV/RADIO [ ] FRIEND/RELATIVE (NAME) _____
[ ] PHYSICIAN/HOSPITAL (NAME) _____ [ ]NEWSPAPER/MAGAZINE (NAME) _____
[ ] OTHER _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE TREATING PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE INCLUDING BUT NOT LIMITED TO ANY APPLICABLE CO-PAYS AND OR DEDUCTIBLES.

X _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE TREATING PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY

X _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S "NOTICE OF PRIVACY PRACTICES" & "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION."

X _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

University Head and Neck Associates

THE MIDWEST SINUS CENTER

Medical Information/HIPAA Release Form

Name: _____ **Date of Birth:** ____/____/____

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

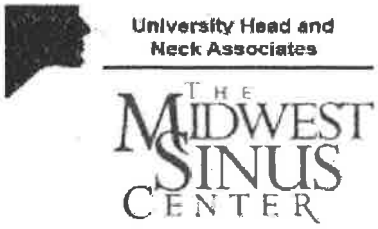
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____



We would like to be able to correspond with your primary care physician. We would also like to correspond with any other referring physicians who might be instrumental in your professional health care. Please supply us with the information needed below:

PATIENT NAME:_____

PRIMARY CARE PHYSICIAN:

NAME:_____

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

NPI(OFFICE USE ONLY):_____

REFERRING PHYSICIAN:

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

NPI(OFFICE USE ONLY):_____

PREFERRED PHARMACY:

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

NPI(OFFICE USE ONLY):_____

EMAIL ADDRESS:_____

PATIENT RIGHTS

1) The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
2) Patients shall receive assistance in a prompt, courteous, and responsible manner.
3) Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
4) Patients have the right to know the identity and status of individuals providing services to them.
5) Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, follow-up care, and possible costs of treatment. All patients will sign an informed consent form after all information has been provided and their questions answered.
6) Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objections with their provider.
7) Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
8) Patients have the right to express complaints about the care they have received and to submit their grievance to the office Supervisor who will complete an "Incident Report" and bring the issue to the attention of the Practice Manager in a timely manner so the grievance may be addressed.
9) Patients have the right to be provided with information regarding emergency and after-hours care.
10) Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient. Patients are informed of their right to change their provider if other qualified providers are available.
11) Patients have the right to a safe and pleasant environment during their stay.
12) Patients have the right to an interpreter if required and the choice of preferred learning or teaching methods. The practice uses verbal and written instructions.
13) Patients have the right to be provided informed consent forms as required by the laws of the State of Illinois.
14) Patients have the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
15) Patients have the right to know marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
16) Patients have the right to know the third party billing service that is used to bill medical claims on behalf of the Practice, and that this service also performs appeals on claims, as well as issuing patient statements and handling patient billing questions.

PATIENT RESPONSIBILITIES

1) Patients are expected to provide complete and accurate medical histories including providing information on all current medications, dietary supplements and any allergies or sensitivities. It is the patients responsibility to keep all scheduled pre- and post-procedure appointments and comply with treatment plans to help ensure appropriate care.
2) Patients are responsible for reviewing and understanding the information provided by their provider. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
3) Patients are responsible for providing insurance information at the time of their visit and to notify the receptionist of any changes in information regarding their insurance or medical information.
4) Patients will be provided, upon request, all available information regarding services available at the office, as well as information about estimated fees and options for payment.
5) Patients are responsible for paying all charges for co-payments, co-insurance, deductibles on non-covered services at the time of the visit unless other arrangements have been made in advance.
6) Patients are responsible for treating Physicians and Staff in a courteous and respectful manner.
7) Patients are responsible for asking questions about their medical care and to seek clarification from their physician of the services to be provided until they fully understand the care they are to receive.
8) Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
9) Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Surgery Center.
10) Patients are responsible for providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
11) Patients will inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

CHIEF COMPLAINT

WHAT ARE YOU BEING SEEN FOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHO IS YOUR REFERRING DOCTOR? _____

PAST MEDICAL HISTORY

- DO YOU HAVE ANY SENSITIVITY OR ALLERGIC REACTIONS TO ANY MEDICATIONS OR FOODS?
  ☐ YES ☐ NO
- IF YES, PLEASE LIST THE NAME OF EACH AND YOUR TYPE OF REACTION:

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

- DO YOU HAVE AN ALLERGY TO LATEX? ☐ YES ☐ NO
- DO YOU HAVE ANY IMPLANTS SUCH AS AN ARTIFICIAL HEART VALVE OR HIP PROSTHESIS?
  ☐ YES ☐ NO IF YES, WHAT TYPE? _____
- PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON FOR HOSPITALIZATION	DATE	COMPLICATIONS

- PLEASE LIST ANY OTHER MAJOR ILLNESSES AND/OR INJURIES: _____

MEDICATIONS

- PLEASE LIST YOUR CURRENT MEDICATIONS. INCLUDE ANY BIRTH CONTROL PILLS, STEROIDS, ANY OVER-THE-COUNTER MEDICATIONS OR ANY RECREATIONAL DRUGS

CURRENT MEDICATIONS	DOSE	FREQUENCY

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

FAMILY HISTORY

PLEASE CIRCLE ANY MEDICAL PROBLEMS THT RUN IN YOUR FAMILY (GRANDPARENTS, PARENTS, SIBLINGS, OR CHILDREN)

DIABETES	ARTHRITIS	PROBLEMS WITH ANESTHESIA	TUBERCULOSIS
HEART DISEASE/HEART ATTACKS	KIDNEY DISEASE	BLEEDING PROBLEMS	IMMUNE DISORDER
HYPERTENSION	THYROID DISEASE (GOITER, ETC.)	CANCER-TYPE:_____	HEARING LOSS
MIGRAINES	ASTHMA	HAY FEVER	SEIZURES
STROKES/TIA'S	BIRTH DEFECTS	OTHER-EXPLAIN:	

SOCIAL HISTORY

- WHAT TYPE OF WORK DO YOU DO? _____
- DO YOU CURRENTLY DRINK OR HAVE YOU EVER USED ALCOHOLIC BEVERAGES IN THE PAST?

  □ YES □ NO IF YES, WHAT? _____ AMOUNT? _____HOW OFTEN? _____ LAST TIME USED? _____
- DO YOU USE / OR HAVE YOU USED TOBACCO IN ANY FORM? □ YES □ NO

  IF YES, WHAT? _____ AMOUNT? _____HOW OFTEN? _____ LAST TIME USED? _____

  DO YOU WANT HELP TO STOP? □ YES □ NO
- FOR PEDIATRIC PATIENTS:

  ARE ALL IMMUNIZATIONS UP TO DATE? □ YES □ NO

  IS THE CHILD EXPOSED TO TOBACCO SMOKE IN THE HOME OR DAYCARE? □ YES □ NO

  IS THE CHILD IN DAYCARE? □ YES □ NO

REVIEW OF SYSTEMS

ARE YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

	YES	NO
CONSTITUTIONAL		
NIGHT SWEATS	□	□
RECURRENT FEVERS	□	□
WEIGHT LOSS IN THE LAST SIX MONTHS	□	□
WAS THE WEIGHT LOSS INTENTIOAL?	□	□
WHAT IS YOUR USUAL WEIGHT? _____LBS.		
EYES		
DOUBLE VISION	□	□
INJURIES	□	□
GLAUCOMA	□	□
WEARING GLASSES/CONTACTS - DATE OF LAST EXAM: _____	□	□
EARS, NOSE, THROAT		
WEARING HEARING AIDS - DATE OF LAST EXAM: _____	□	□
HEARING LOSS	□	□
EAR PAIN	□	□
EAR INFECTIONS	□	□
RINGING IN EARS CIRCLE: LEFT RIGHT BOTH	□	□
DRAINAGE FROM EARS CIRCLE: LEFT RIGHT BOTH	□	□
BALANCE PROBLEMS (VERTIGO OR SPINNING)	□	□
NOSE BLEEDS	□	□
NASAL CONGESTION	□	□

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

EARS, NOSE, THROAT (CONT'D)	YES	NO
NASAL DRAINAGE	☐	☐
INABILITY TO SMELL	☐	☐
SINUS PROBLEMS	☐	☐
SORE THROATS	☐	☐
MOUTH SORES	☐	☐
HOARSENESS	☐	☐
DIFFICULTY SWALLOWING	☐	☐
SEASONAL ALLERGIES (HAYFEVER)	☐	☐
CARDIOVASCULAR		
CHEST PAIN OR ANGINA - DATE OF LAST EKG: _____	☐	☐
HIGH BLOOD PRESSURE	☐	☐
IRREGULAR PULSE	☐	☐
HEART MURMUR	☐	☐
ABNORMAL HEART ANATOMY	☐	☐
HAS A PHYSICIAN EVER RECOMMENDED ANTIBIOTICS PRIOR TO SURGICAL PROCEDURES (DENTAL WORK) OR BECAUSE OF A HEART MURMUR OR IMPLANT?	☐	☐
RESPIRATORY		
ASTHMA	☐	☐
CHRONIC COUGH	☐	☐
EMPHYSEMA	☐	☐
SHORTNESS OF BREATH	☐	☐
BRONCHITIS/PNEUMONIA	☐	☐
LUNG CANCER	☐	☐
BLOODY SPUTUM	☐	☐
TUBERCULOSIS	☐	☐
DATE OF LAST CHEST X-RAY: _____		
GASTROINTESTINAL		
INDIGESTION OR PAIN WITH EATING	☐	☐
CHRONIC NAUSEA/VOMITING	☐	☐
LIVER DISEASE (HEPATITIS)	☐	☐
JAUNDICE	☐	☐
ULCERS OR GASTRITIS	☐	☐
COLON OR STOMACH CANCER	☐	☐
GENITOURINARY		
RECURRENT URINARY TRACT INFECTIONS	☐	☐
BLOOD IN YOUR URINE	☐	☐
PROSTATE CANCER (MALES)	☐	☐
UTERINE OR CERVICAL CANCER (FEMALES)	☐	☐
MUSCULOSKELETAL		
BROKEN BONES - LIST: _____	☐	☐
CHRONIC ARM OR LEG WEAKNESS	☐	☐
ARTHRITIS	☐	☐
INTEGUMENTARY		
SKIN CANCER	☐	☐
SKIN DISEASE	☐	☐

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

	YES	NO
NEUROLOGICAL		
FAINTING SPELLS OR "BLACKING OUT"	☐	☐
SEIZURES	☐	☐
DIFFICULTY WITH YOUR SPEECH	☐	☐
FREQUENT HEADACHES OR MIGRAINES	☐	☐
STROKES	☐	☐
PSYCHIATRIC		
ANXIETY	☐	☐
DEPRESSION	☐	☐
OTHER PSYCHIATRIC DISORDER/TREATMENT: _____	☐	☐
ENDOCRINE		
DIABETES	☐	☐
THYROID DISEASE	☐	☐
EXCESSIVE THIRST OR URINATION	☐	☐
HORMONE PROBLEMS	☐	☐
ARE YOU PREGNANT OR BREASTFEEDING? (FEMALES)	☐	☐
HEMATOLOGIC/LYMPHATIC		
ANEMIA	☐	☐
HEMOPHILIA/EASY BLEEDING TENDENCIES	☐	☐
PERSISTENT SWOLLEN GLAND OR LYMPH NODES	☐	☐
BLOOD TRANSFUSIONS - IF YES, WHEN? _____	☐	☐
IMMUNOLOGIC		
IMMUNOLOGICAL DISORDERS (IMMUNE DEFICIENCY)	☐	☐

HAVE YOU EVER HAD ANY RADIATION TREATMENT?

IF YES, PLEASE EXPLAIN: _____

SIGNATURE _____ DATE: _____

(PATIENT/PERSON COMPLETING FORM)

RELATIONSHIP TO PATIENT: _____

REVIEWING STAFF SIGNATURE	DATE	NO CHANGES	CHANGES AS NOTED
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

COMMENTS:

Nasal Obstruction Symptom Evaluation (NOSE) Assessment

PATIENT'S NAME: _____ TODAY'S DATE: _____

Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey.

Over the past ONE month, how much of a problem were the following conditions for you?
Please **(circle)** the most correct response for each category.

	Not a Problem	Very Mild Problem	Moderate Problem	Fairly Bad Problem	Severe Problem
1. Nasal congestion or stuffiness	0	1	2	3	4
2. Nasal blockage or obstruction	0	1	2	3	4
3. Trouble breathing through my nose	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4
Total Score					
NOSE Score (Multiply your total score x5)					

A score of 0 means no problems with nasal obstruction and a score of 100 means the worst possible problems with nasal **obstruction**. Instrument was not designed to be used with individual patient data or to predict outcome on individuals. *Otolaryngology–Head and Neck Surgery: 162-163 STEWART et al February 2004.*

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:_____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5		○
2. Nasal Blockage	0	1	2	3	4	5		○
3. Sneezing	0	1	2	3	4	5		○
4. Runny nose	0	1	2	3	4	5		○
5. Cough	0	1	2	3	4	5		○
6. Post-nasal discharge	0	1	2	3	4	5		○
7. Thick nasal discharge	0	1	2	3	4	5		○
8. Ear fullness	0	1	2	3	4	5		○
9. Dizziness	0	1	2	3	4	5		○
10. Ear pain	0	1	2	3	4	5		○
11. Facial pain/pressure	0	1	2	3	4	5		○
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		○
13. Difficulty falling asleep	0	1	2	3	4	5		○
14. Wake up at night	0	1	2	3	4	5		○
15. Lack of a good night's sleep	0	1	2	3	4	5		○
16. Wake up tired	0	1	2	3	4	5		○
17. Fatigue	0	1	2	3	4	5		○
18. Reduced productivity	0	1	2	3	4	5		○
19. Reduced concentration	0	1	2	3	4	5		○
20. Frustrated/restless/irritable	0	1	2	3	4	5		○
21. Sad	0	1	2	3	4	5		○
22. Embarrassed	0	1	2	3	4	5		○

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England.

NAME: _____ DATE: _____

1. **OVERALL, HOW WOULD YOU RATE YOUR HEALTH?**

2. _____EXCELLENT
3. _____VERY GOOD
4. _____FAIR
5. _____POOR

2. PLEASE INDICATE THE OVERALL AMOUNT OF DISTURBANCE OR "BOTHER" THAT YOU EXPERIENCE IN YOUR LIFE AS A RESULT OF YOUR RHIOSINUSITIS PROBLEMS:

1. _____NOT BOTHERED
2. _____BOTHERED A LITTLE, BUT NOT A LOT
3. _____BOTHERED MORE THAN A LITTLE, BUT NOT A LOT
4. _____BOTHERED A LOT
5. _____EXTREMELY BOTHERED

3. **HOW LONG HAVE YOU BEEN EXPERIENCING YOUR CURRENT SYMPTOMS?**

1. _____I AM NOT EXPERIENCING ANY SYMPTOMS NOW.
2. _____2-4 WEEKS.
3. _____GREATER THAN 4 WEEKS BUT LESS THAN 6 WEEKS
4. _____6 WEEKS TO 3 MONTHS
5. _____GREATER THAN 3 MONTHS
6. _____UNSURE

4. **WHAT RHINOSINUSITIS MEDICATIONS OR TREATMENTS ARE YOU USING NOW OR HAVE USED SINCE DEVELOPING YOUR PRESENT SYMPTOMS? (PLEASE CHECK ALL THAT APPLY)**

0. _____NONE
1. _____NON-DRUG METHODS (EXAMPLES: STEAM INHALATIONS, WARM PACKS)
2. _____SALINE NASAL SPRAYS, DROPS, OR NASAL EMOLLIENTS.
3. _____"OVER THE COUNTER" DECONGESTANT NASAL SPRAYS OR DROPS (EXAMPLES: NEOSYNEPHRINE, AFRIN)
4. _____DECONGESTANTS (EXAMPLES: SUDAFED)
5. _____ANTIHISTAMINES (EXAMPLES: BENADRYL, CLARITIN, CLARINEX, ALLEGRA, ZYRTEX)
6. _____BOTH ANTIHISTAMINE AND DECONGESTANT (EXAMPLES: CLARITIN –D, ALLEGRA-D)
7. _____ANTIBIOTICS (EXAMPLES: AMOXICILLIN, ERYTHROMYCIN, CEFTIN, LEVAQUIN, Z-PACK, BIAXIN)
8. _____ORAL STEROIDS (EXAMPLES: PREDNISONE, MEDROL)
9. _____NASAL CROMOLYN SPRAYS (EXAMPLE: NASALCROM)
10. _____NASAL STEROID SPRAYS (EXAMPLES: FLONASE, NASONEX, RHINOCORT)
11. _____ALLERGY SHOTS

5. **HAVE YOU EVER HAD SINUS OR NOSE SURGERY? IF SO, PLEASE DESCRIBE:**

DATE	TYPE
_____	_____
_____	_____
_____	_____

THANK YOU FOR YOUR PARTCIPATON!

UPDATE: 3/16/05