LAST NAME: _____ FIRST NAME: _____ M.I.: _____

DATE OF BIRTH: _____ GENDER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

OCCUPATION: _____ BUSINESS PHONE #: _____

SPOUSE'S NAME: _____ SPOUSE'S PHONE #: _____

PATIENT EMAIL: _____

PHARMACY NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY INFORMATION—IN THE EVENT OF AN EMERGENCY PLEASE NOTIFY:

NAME:_____ RELATIONSHIP:_____ PHONE #:_____

INSURANCE INFORMATON—POLICY HOLDER:

NAME OF POLICY HOLDER: _____ RELATIONSHIP: _____ DATE OF BIRTH: _____

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

☐INSURANCE PLAN ☐INTERNET SEARCH ☐FRIEND/RELATIVE

☐PHYSICIAN/HOSPITAL(NAME)_____ ☐OTHER_____

CONSENT FOR TREATMENT/AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY, RECEIPT OF PRIVACY NOTICE/HEALTH INFORMATION USE NOTICE

-I consent to examination and treatment that may be required during my office visit. I authorize any emergency care that is deemed necessary by the physician or physician assistant during the visit. I understand that I am seeking care from a specialist in otolaryngology, who may determine that it is necessary to perform a nasal endoscopy or laryngoscopy as part of the examination.

-I authorize University Head and Neck Associates to release to my insurance company or its representatives, any information regarding my diagnosis and/or records of any treatment or examination rendered to me that is required to process my claims for benefits.

-I authorize and request my insurance company pay directly to University Head and Neck Associates the amount due to me in pending claims for medical treatment/services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

-I understand that I am directly responsible for services rendered which are not paid by insurance, including charges allocated to my deductible and co-insurance. (See payment policy for more details.)

-I certify to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify University Head and Neck Associates in the event of any changes in the information contained on any/all form(s) completed.

-I acknowledge having been provided with a copy of University Head and Neck Associates' Patient *Privacy Notice, also available on their website*. The notice provides detailed information about how University Head and Neck Associates may use and disclose a patient's protected health information. I understand the privacy practices described in the notice may change.

X_____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

HIPAA Disclosure Form

Patient Name: _____ Date of Birth: _____

Address: _____

Cell Phone No. _____ Home Phone No. _____

Email Address: _____

Midwest Sinus Center Physician: _____

May we identify ourselves over the phone? · Yes · No May we leave messages? · Yes · No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information. (appointments, lab/imaging results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____

Signature: _____ Date: _____

University Head and Neck Associates

THE MIDWEST SINUS CENTER

UNIVERSITY HEAD AND NECK ASSOCIATES' PAYMENT/BILLING POLICY

We want to thank you for choosing our practice for your Ears, Nose and Throat care. It is important to us that you are fully informed of our payment policy.

PAYMENT EXPECTED AT TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. University Head and Neck Associates, S. C. ("UHANA") accepts cash, VISA, MasterCard and Discover. There is a service charge of $25.00 for returned checks.

Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments.

If your account is forwarded to collections by UHANA there will be a charge of $50 to cover administrative expenses incurred in submitting a claim to a collection agency, in addition to any amount owing.

REFUNDS:

Patient/guarantor credits in amounts less than $50 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts of $50 or greater will be automatically refunded to the patient/guarantor.

INSURANCE:

It is the patient's responsibility to provide their current insurance card and or referral at the time of service. If you fail to provide your current insurance/referral information, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. You are expected to pay your co-payments at the time of service. If we have not received payment from your insurance company or if payment is denied with 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether, by you or by your insurance carrier.

Please note your insurance plan determines your co-pay/co-insurance/deductible; your plan also determines what services it covers and does not cover. Your Explanation of Benefits should outline this information.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e. PPPG, HMO) you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always a guarantee for payment.

MEDICAL EXPENSES RELATING TO A CLAIM AGAINST A THIRD PARTY:

Patients shall be financially responsible for medical services related to any accident, personal injury, or worker's compensation claim. It is also the patient's responsibility to notify UHANA if the service is due to such incidents. While we will assist our patients to the extent possible in such situations, UHANA does not bill any third-party insurer.

DISABILITY/FMLA/INSURANCE/ OTHER THIRD-PARTY FORMS:

A $25.00 flat fee, pre-paid will be charged for 3 or more pages. Please allow 7 – 10 business days for them to be completed.

I have read and understand the Payment Policy of UHANA. I agree to assign insurance benefits to UHANA whenever necessary. I also agree that if my account must be sent to a collection agency, in addition to the amount owed, I will also be responsible for a $50 fee.

_____

Printed Name

_____ _____

Signature of insured or authorized representative Date

University Head and Neck Associates

THE MIDWEST SINUS CENTER

24 Hour Cancellation & "No Show" Fee Policy

As a practice, our goal is to offer the best possible care to our patients, and we recognize that everyone's time is valuable. We understand that circumstances may arise which make it impossible for you to keep your scheduled appointment.

While we are understanding of such circumstances, we do require that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care.

Therefore, the physicians of University Head and Neck Associates reserve the right, at their discretion, to charge a fee of $50.00 for all missed appointments not cancelled within a 24 hour advance notice period ("No Shows"), unless there is a compelling reason for the failure to give notice.

A No Show fee will be billed to the patient. The fee is not covered by insurance and must be paid prior to your next appointment. Multiple No Shows in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name **Date**

_____

Signature

Nasal Obstruction Sympton Evaluation (NOSE) Assessment

Patient's Name: _____ Todays Date: _____

To better understand the impact of nasal obstruction on your quality of life, please complete 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.	No 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 =	
				Total X5 =	

Sino-Nasal Outcome Test (SNOT-22) Questionaire

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability.

Please rate your problems as they have been over the past two weeks. Thank you for your participation.

A.) Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how bad it is.

Please Circle 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**	**Most Important items**
1. Need to blow nose							☐
2. Sneezing							☐
3. Runny Nose							☐
4. Nasal Obstruction							☐
5. Dryness							☐
6. Cough							☐
7. Post Nasal discharge							☐
8. Loss of smell or taste							☐
9. Thick nasal discharge							☐
10. Dizziness							☐
11. Ear Pain							☐
12. Ear fullness							☐
13. Facial Pain/pressure							☐
14. Difficulty falling asleep							☐
15. Lack of a good nights sleep							☐
16. Waking up at night							☐
17. Waking up tired							☐
18. Fatigue							☐
19. Reduced productivity							☐
20. Reduced concentration							☐
21. Frustrated/restless/irritable							☐
22. Sad							☐
23. Embarrassed							☐
TOTALS (each Column):							
Grand Total Score (all coumns together):							

B. Please check off the most important items affecting your health in the last column (max of five items)

University Head and Neck Associates

Midwest Sinus Center

Medical History Questionaire

Patient Name: _____ Date: _____

DOB: _____

Referring Physician: _____ PCP: _____

Chief Complaint: What are you being seen here for today? _____

How long have you had this problem? _____

Do you have any sensitivity or allergic reaction to medications, food, or Latex? **Yes No**

*If yes, Please list the name of each and your type of reaction below:

1.) _____ 2.) _____ 3.) _____

Please list any surgeries or Hospitalizations you have had, the date, and if there were any complications:

1.) _____ 2.) _____ 3.) _____

4.) _____ 5.) _____ 6.) _____

Have you ever had any Radiation treatment? **Y N** If Yes, Please explain: _____

Please list any other major illnesses and/or injuries: _____

Medications: Please list your current medications and include any birth control, steroids, over the counter meds or recreational drugs.

Name: _____ **Reason:** _____ **Dose:** _____

Name: _____ **Reason:** _____ **Dose:** _____

Name: _____ **Reason:** _____ **Dose:** _____

Name: _____ **Reason:** _____ **Dose:** _____

Name: _____ **Reason:** _____ **Dose:** _____

Name: _____ **Reason:** _____ **Dose:** _____

Family History:

Please circle any medical problems that run in your family (grandparents, parents, siblings, or children)

Diabetes	Seizures	Bleeding Problems
Migraines	Hearing Loss	Cancery-Type:_____
Thyroid Disease (goiter, etc)	Immune Disorder	Problems with Anethesia
Heart Disease	Kidney Disease	Stokes/TIA's
Heart Attacks	Hay Fever	Hypertension
Asthma	Arthritis	Tuberculosis

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, how many drinks? 1-2 3-4 5 or more

How often? Daily 1-3 times a week 1-3 times a month

Do you use/or have you used tobacco in any form? **Yes No**

If yes, Type? Cigarettes Vaping Chew Other: _____

How often ? Light (1-9 cigs/day) Moderate (10-19 cigs/day) Heavy (20-39 cigs/day)

Review of Systems

University Head and Neck Associates
Midwest Sinus Center

Are you currently or have you had problems with any of the below:

Constitutional

Night Sweats	Y	N
Recurrent Fevers	Y	N
Weight loss in the last 6 months	Y	N
Was the weight loss intentional?	Y	N
What is your usual weight?_____ lbs		

Respiratory

Asthma	Y	N
Chronic Cough	Y	N
Emphysema	Y	N
Shortness of breath	Y	N
Bronchitis/Pneumonia	Y	N
Sputum production	Y	N
Lung Cancer	Y	N
Tuberculosis	Y	N
Date of last Chast X-ray:_____		

Cardiovascular

Chest Pain or Angina	Y	N
Date of last EKG:_____		
Irregular Pulse	Y	N
High Blood pressure	Y	N
Has a physician ever reccomended antibiotics prior to a surgical procedures (dental work) or because of a heart murmur or implant	Y	N

Ears, Nose, Throat

Hearing Loss	Right / Left / Both	Y	N
Wearing Hearing Aids	Right / Left / Both	Y	N
Date of last exam:_____			
Ear Pain	Right / Left / Both	Y	N
Ear infections	Right / Left / Both	Y	N
Ringing in Ears	Right / Left / Both	Y	N
Drainage from Ears	Right / Left / Both	Y	N
Balance Problems (Vertigo/Spinning)		Y	N
Nose Bleeds		Y	N
Nasal Congestion		Y	N
Nasal Drainage		Y	N
Inability to Smell		Y	N
Sinus Problems		Y	N
Sore Throats		Y	N
Mouth Sores		Y	N
Hoarseness		Y	N
Seasonal Allergies		Y	N

Integumentary

Skin Cancer	Y	N
Skin Disease	Y	N

Genitourinary

Recurrent Urinary Tract Infections	Y	N
Blood in urine	Y	N
Prostate Cancer	Y	N
Uterine or Cervical Cancer	Y	N
Kidney stones	Y	N

Gastrointestinal

Indegestion or pain with eating	Y	N
Chronic nausea or vomiting	Y	N
Liver Disease (Hepatitis)	Y	N
Jaundice	Y	N
Ulcers or Gastritis	Y	N
Colon or Stomach Cancer	Y	N

Psychiatric

Anxiety	Y	N
Depression	Y	N
Other Pshychiatric Disorder/treatment:	Y	N

Hematologic/Lymphatic

Anemia	Y	N
Hemophilia or Easy Bleeding Tendencies	Y	N
Persistent Swollen Gland or Lymph Nodes	Y	N
Blood Transfusions- If yes, when?_____	Y	N

Neurological

Fainting spells or blacking out	Y	N
Seizures	Y	N
Difficulty with speech	Y	N
Frequent headaches or migraines	Y	N
Strokes	Y	N

Endocrine

Diabetes	Y	N
Thyroid disease	Y	N
Excessive thirst or urination	Y	N
Hormone problems	Y	N
Are you pregnant or breastfeeding?	Y	N

Musculoskeletal

Broken Bones	Y	N
Chronic arm or leg weakness	Y	N
Arthritis	Y	N

Eyes

Blurred vision	Right / Left / Both	Y	N
Injuries	Right / Left / Both	Y	N
Glaucoma	Right / Left / Both	Y	N
Wearing glasses/ contacts		Y	N

Immunologic

Immuological disorders (immune deficiency)	Y	N

Signature (patient/ person completing form):_____

Relationship to Patient:_____ Date:_____