Revised 2018.02.19

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 _____ Day _____ 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 ☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ 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: _____

Symptoms Review

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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	☐ Yes ☐ No	Sense of Smell Problem	☐ Yes ☐ No	Sweating at Night	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Throat Clearing	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No
Weight Loss/Gain	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No	Joint Aches	☐ Yes ☐ No
Daytime Sleepiness	☐ Yes ☐ No	Vocal Problems	☐ Yes ☐ No	Muscle Aches	☐ Yes ☐ No
Sneezing	☐ Yes ☐ No	Ear Drainage	☐ Yes ☐ No	Headache	☐ Yes ☐ No
Environmental Allergy	☐ Yes ☐ No	Ear Noises/Ringing	☐ Yes ☐ No	Passing Out	☐ Yes ☐ No
Post-Nasal Drip	☐ Yes ☐ No	Headache	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Ear Fullness	☐ Yes ☐ No	Sinus Pressure/Pain	☐ Yes ☐ No	Numbness, Tingling	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Snoring/Apnea	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Throat Pain	☐ Yes ☐ No	Anxiety or Panic	☐ Yes ☐ No
Coughing Blood	☐ Yes ☐ No	Throat Dryness/Itching	☐ Yes ☐ No	Eye Pain	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No	Watery or Itchy Eyes	☐ Yes ☐ No
Feel Warmer Than Others	☐ Yes ☐ No	Upset Stomach	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Feel Cooler Than Others	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No	Itching	☐ Yes ☐ No
Ear Pain or Itch	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Hives	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Palpitations	☐ Yes ☐ No	Skin or Hair Changes	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Swollen Glands	☐ Yes ☐ No	Imbalance or Woozy	☐ Yes ☐ No
Nasal Congestion	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No	Recent Head Trauma	☐ Yes ☐ No

SOCIAL HISTORY

Do you currently smoke?	☐ Yes ☐ No	If yes, how much?	
Did you smoke in the past?	☐ Yes ☐ No	If yes, how long / how much?	
Do you drink caffeinated beverages?	☐ Yes ☐ No	If yes, how many per day?	
Do you use recreational drugs?	☐ Yes ☐ No	If yes, how often?	
Do you drink alcohol?	☐ Yes ☐ No	If yes, how often?	

MEDICAL HISTORY

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

Allergy Problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Sleep Problems/Apnea	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No	Breathing Problems	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Sinus Infection	☐ Yes ☐ No

Other medical diagnosis: _____

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	☐ Yes ☐ No		Bleeding Disorders	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No		Allergy/Eczema	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Arthritis	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No		Anesthesia Problems	☐ Yes ☐ No	
Hearing Loss	☐ Yes ☐ No		Sinus Problems	☐ Yes ☐ No	

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MEDICATIONS CURRENTLY BEING TAKEN

	Name of Medication	Dosage / Freqency	Reason / Purpose
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

DRUG/MEDICAL ALLERGIES

Name of medication patient is allergic to:	Type of reaction to 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	

Are you allergic to latex? ☐Yes ☐No

Are you allergic to medical tape? ☐Yes ☐No

ALLERGY RELATED LIVING CONDITIONS

What type of home do you live in? (e.g. Wood, Stucco)

Type of heating (e.g. Gas, Electric, Wood Burning Stove)

Type of cooling (e.g. Refridgerated, Swamp)

Do you have down bedding:

Does your home have a water leak:

Mold Growth? If yes, Where?

SURGERY HISTORY (INCLUDING TONSILES AND ADENOIDS) AND HOSPITALIZATION

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

COMMUNICATION & MESSAGING

INITIAL

I agree, and 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: _____

Name of Person: _____ Phone: ____ - ____ - _____ Relationship to Me: _____

CONSENT FOR TREATMENT

INITIAL

I agree, and 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

INITIAL

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:

Steve Harris
3917 West Rd., Suite 200 | Los Alamos, NM 87544
Phone: 505.661.4147 | Fax: 505.661.0075

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

INITIAL

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.

Your insurance may require that you obtain a referral from your primary care physician prior to visiting an ENT practice. If a referral is required but is not on file at the time of service, the financially responsible party will be billed.

Insurance cards and identification must be presented at every visit. Correct and current insurance information is required for prompt and proper payment of claims. Patients are responsible to know what their insurance will cover. A prior authorization is not a guarantee of services covered.

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. If you have three no-show appointments, we will be unable to fulfill further appointments for you.

A complete ENT exam may require the use of a 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.

Printed Name: _____

Signature: _____ Todays Date: Month_____ Day_____ Year_____

(Patient or Guardian if patient is under 18.)