Patient Registration Form

NAME:_____TODAY'S DATE:_____

ADDRESS:_____DATE OF BIRTH:_____

CITY: _____STATE:_____ZIP:_____

RACE:_____PREFERRED LANGUAGE:_____ETHNICITY_____

SEX: M F MARITAL STATUS: S M W D SS#:_____

HOME PHONE: (____)_____EMPLOYER:_____

CELL PHONE: (____)_____E-MAIL :_____

WORK PHONE: (____)_____

LOCAL PHARMACY :_____ MAIL PHARMACY:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____
PHONE :(____)_____

PRIMARY CARE PHYSICIAN_____PHONE:(____)_____
If not local

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Did you sustain an injury at work? Y N
Are your injuries accident related? Y N
Are you covered under a union policy? Y N
Is your spouse or other family member employed? Y N

PRIMARY INSURANCE:_____SECONDARY INSURANCE:_____

SUBSCRIBER: (if other than patient)

NAME:_____RELATIONSHIP:_____

DATE OF BIRTH:_____ SEX: M F SS#:_____

ADDRESS: (If different)_____EMPLOYER:_____

HOME PHONE: (If different)_____ WORK PHONE:_____

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Patient Medical History (ROS)

Name:_____ Age:_____ Date:_____
Reason For Appointment:_____
Primary Doctor:_____ Who Referred You:_____
Height:_____Weight:_____
If you are age 65 or over, do you have an Advance Care Plan (living will)? Yes No
Do you use any tobacco products? Yes No _____
Have you smoked 100 cigarettes in your lifetime? Yes No CURRENT FORMER NEVER

Do you drink alcohol?	Yes	No	How much? _____	How often?_____
Do you use recreational drugs?	Yes	No	How much? _____	How often?_____
Do you take aspirin?	Yes	No	How much? _____	How often? _____
Are you pregnant?	Yes	No		
Do you experience any dizziness?	Yes	No		
Have you had any falls in the last year?	Yes	No		

Do you have any of the following medical problems? If yes, please explain.

Heart Disease	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Thyroid Problems	Y	N
High Cholesterol	Y	N	Rheumatic Fever	Y	N
Heart Murmurs	Y	N	Stomach Problems	Y	N
Liver Problems	Y	N	Respiratory Problems	Y	N
Arthritis	Y	N	Seizures or Epilepsy	Y	N
Blood Disorders	Y	N	Cancer	Y	N
Hepatitis	Y	N	Infectious Disease	Y	N
If yes to any of above please explain:			Other:_____		

_____
_____

Do you have any of the following symptoms now? (Choose all that apply)

Shortness of Breath_____	Weight Loss_____	Fatigue_____
Visual Disturbance_____	Hearing Loss_____	Cough_____
Nasal Congestion_____	Sore Throat_____	Fever_____
Seasonal Allergies_____	Chest Pain_____	Weakness_____
Abdominal Pain_____	Pain on Urination_____	Numbness_____
Muscle Joint Pain_____	Hoarseness_____	Rash_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____

*****PLEASE SEE REVERSE SIDE *****

PLEASE ANSWER *ALL* QUESTIONS

Patient Medical History

Name:_____ Age:_____ Date:_____

Pharmacy:_____ Mail-in Pharmacy:_____

Please list all medications including vitamins:

Medication: Dose: Per Day:

Are you allergic to any medications? _____

Any previous surgeries?_____

Any illnesses run in the family?_____

Have you had any recent labs, CT, MRI, XRAY or ultrasound done? (if so please list study and where it was performed):_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____

NJ REGIONAL EAR, NOSE & THROAT CENTER, LLC

Edward I Engle, D.O., F.A.O.C.O.
Teri Nelson, PA-C

Authorization for Release of Information to Family Members/Friends

Patient Name_____ Date of Birth_____

Many of our patients allow family members/friends such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members/friends, you must sign this form. By signing this form, this information will be released to the family members/friends indicated below.

I authorize NJ Regional Ear, Nose & Throat Center, LLC to release my medical and or billing information to the following individual(s):

1._____Relation to Patient:_____

2._____Relation to Patient:_____

3._____Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient(s) is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing at any time. ***It is the patient's responsibility to notify the office if any of the above recipients' need to be updated/removed.***

Signature:_____Date:_____

PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH IINFORMATION

I consent to have NJ Regional Ear, Nose & Throat Center, LLC disclose my protected health information for payment, treatment and healthcare operations, and for such other purposes that are permitted under HIPAA regulations without written authorization. Notice of Privacy Practices available upon request.

OFFICE PROCEDURES/FINANCIAL POLICIES

I hereby give consent to NJ Regional Ear, Nose & Throat Center, LLC to provide treatment and service(s) the assigned provider may deem necessary. I authorize any holder of medical information about me to release to any appropriate insurance company and its agent's information needed to determine these benefits payable for related services.

- I understand and agree that (regardless of my insurance status); I am ultimately responsible for any balances on my account for professional services rendered. .
- I understand that if my insurance company requires a co-payment, it is my responsibility and is due at the time of service, otherwise a charge of $10 will be incurred.
- I understand that I am responsible for charges not covered by my insurance policy, such as deductibles and or coinsurance.
- I understand that I am responsible for a fee of $25.00 for any returned check.
- I understand that I am responsible for a fee of $25.00 for not cancelling an appointment 24 hours prior to the appointment time, or for a "no show" appointment.
- I understand that should I need private disability forms filled out by my provider that I am responsible for a fee of $15.00.
- I understand that if my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 6%, court costs, and attorney fees, as allowed by law

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby consent and grant permission for Practitioners employed by NJ Regional Ear, Nose & Throat Center, LLC to discuss my medical treatment with my referring physician, primary care physician, and or any other healthcare practitioner, relating to my care and treatment. I hereby authorize any practitioner examining and/or treating me, to release to any third party(such as an insurance company or governmental agency)any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a lifetime release of information. I hereby consent and authorize NJ Regional Ear, Nose & Throat Center, LLC to file claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to NJ Regional Ear, Nose & Throat Center, LLC for any services rendered for treatment. Any services for which assignment is accepted but are not covered under my insurance policy are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to all the above.

Patient's Signature	Patient's Printed Name	Date Signed
Representative's Signature	Representative's Printed Name	Date Signed

**Disclaimer: Failure to sign this form will discontinue submission of claims(s) to appropriate insurance company and patient will be responsible for payment at time of service.

NJ REGIONAL EAR, NOSE & THROAT CENTER

COVID 19 RISK INFORMED CONSENT

I _____(Patient) understand that COVID -19, has been declared a worldwide pandemic by the world health organization. I further understand that COVID-19 is extremely contagious and believed to be spread by person-to-person contact ; as a result, federal and state agencies recommend social distancing and **NJ Regional Ear, Nose & Throat Center** is closely monitoring this situation and have placed reasonable preventative Measures aimed at reducing the spread of COVID19. However, Given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and staff at your offices to proceed with providing care.

I have read, or have had read to me, the above COVID-19 risk consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had the opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and any future condition(s) for which I seek care from this office

Patient Signature:_____

Name:_____

Date: _____