



**EAR, NOSE & THROAT ASSOCIATES OF NORTHERN COLORADO, P.C.**

**REGISTRATION INFORMATION**

**BRUCE SMITH, M.D.**

**MEGHAN ABRAHAM, Au.D.**

**AMY MULLIN, Ph.D.**

PATIENT'S FULL LEGAL NAME (PLEASE PRINT ON THE LINE ABOVE THROUGHOUT THIS FORM)

PARENT'S NAME (IF THE PATIENT IS A CHILD)

ADDRESS: STREET NUMBER P.O. BOX CITY STATE ZIP

PHONE ( HOME/WORK/CELL) SECONDARY PHONE ( HOME/WORK/CELL) Gender : M / F

E-mail address: Primary Physician:

PATIENT'S SOCIAL SECURITY NUMBER DOB AGE

RACE: ETHNICITY: LANGUAGE:

CONTACT IN CASE OF EMERGENCY: Nearest LOCAL contact not living with you. (RELATIONSHIP) PHONE

Insurance Card Holder's Social Security # Card Holder's DOB Through Employer? Yes No IF YES, NAME

CIRCLE STATUS OF THE PATIENT: CHILD SINGLE MARRIED WIDOWED DIVORCED

Patient or Responsible party's occupation:

Employer and address:

Phone Number:

If other than yourself, name of person responsible for your bill: Relationship:

Responsible person's address:

Responsible person's employer: Work #:

Referral Type (PLEASE CHECK ONE):

- Dex Yellow pages  Dex Knows Online  Front Porch Direct  The Yellow Book (NOT YELLOW PAGES)
- Internet Search:  Friend:  Physician/Medical Facility:

Have you or any member of your family ever been treated in this office? YES NO

If so, when? Name: Relation:

**ASSIGNMENT OF BENEFITS AND NOTICE OF PATIENT INFORMATION PRACTICES**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to the Ear, Nose and Throat Associates of Northern Colorado, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. In the event my insurance REQUIRES A REFFERAL, AND I DO NOT PROVIDE ONE AT THE TIME OF SERVICES, I AM RESPONSIBLE FOR ANY CHARGES INCURRED. I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all medical and pharmacy records to ENT Associates of Northern Colorado and my primary and referring physicians. I hereby authorize release of copies of this information sheet to any hospital I may be admitted to. I also authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim. I acknowledge receipt of the Notice of Patient Information Practices.

SIGNATURE

DATE

**PATIENT HISTORY SHEET**

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

MEDICATION ALLERGIES:            YES        NONE

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ENVIRONMENTAL OR FOOD ALLERGIES:    YES        NONE

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CURRENT MEDICATIONS:

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ALL PREVIOUS SURGERIES, INCLUDING THE YEAR:

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PLEASE INDICATE ALL PREVIOUS ILLNESSES AND HEALTH PROBLEMS FOR BOTH YOURSELF AND YOUR FAMILY.  
(CHECK APPROPRIATE BOX)

	YOURSELF		FAMILY		RELATION		YOURSELF		FAMILY		RELATION
	YES	NO	YES	NO			YES	NO	YES	NO	
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA OR LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	PROSTATE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHEST PAIN WITH EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	POLIO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NERVE OR PSYCHIATRIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RINGING IN THE EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	UNUSUAL CHILDHOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEARING LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ULCER OR STOMACH DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NECK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FEVERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
YELLOW JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV VIRUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

OTHER PHYSICAL RESTRICTIONS: \_\_\_\_\_

**CIRCLE THE APPROPRIATE CHOICES BELOW**

<b>TOBACCO USE:</b>	<b>ALCOHOL USE:</b>	<b>ASPIRIN USE:</b>	<b>RECREATIONAL DRUGS:</b>
YES / NO	YES / NO	YES / NO	YES / NO
PAST / PRESENT	PAST / PRESENT	PAST / PRESENT	PAST / PRESENT



## Ear, Nose and Throat Associates of Northern Colorado

### FINANCIAL POLICY

Welcome to Ear, Nose and Throat Associates of Northern Colorado, P.C. Please take a few minutes to review the following information. We hope you will understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients.

#### PATIENT RESPONSIBILITIES:

Copayments: We do not bill for copayments. Copayments are due at the time of service.

Referrals: if your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred.

**Cancellations: A \$25.00 cancellation fee will be assessed if the appointment is not cancelled 24 hours in advance.**

A \$25.00 fee will be assessed on returned checks.

If you have health insurance, with which we participate:

- We will bill your insurance claim for you
- We expect any required copayment at the time of service

If we do not participate with your insurance:

- We will do a courtesy billing for you
- We expect payment of deductibles and/or percentages to be paid in full after we have issued you a statement

**If you do not have insurance, we expect payment at the time of service. We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER and CARE CREDIT (3-month plan).**

**Surgical deductibles will be collected prior to surgery. Co-insurance is due after a statement has been issued. If payment arrangements need to be made, payment in full must be within 90 days. A \$25.00 rebilling fee will be assessed to accounts after 90 days. Accounts over 90 days are subject to collection. If your account is placed in full collection or if we write off a bad debt you will be dismissed from this practice.**

I have read and understand the above.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

#### Release of (Medical) Records

I authorize this clinic to furnish medical information regarding the treatment of my current injury/illness to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related injuries).

Date: \_\_\_\_\_

Signature: \_\_\_\_\_