Bernard J. Durante, MD, FACS

PLYMOUTH
EARS NOSE & THROAT

Anit T. Patel, MD, MBA, FACS

Patient Registration

Name:_____ Age: _____ Sex:_____ DOB:_____

Mailing Address:_____

City:_____ State: _____ Zip: _____

EMAIL:_____

Best Telephone Number: (please check one) ❑ Home: _____ ❑ Cell: _____

❑ Work: _____ ❑ Other: _____

Primary Care Physician:_____

Pharmacy:_____ City:_____

Emergency Contact:_____Phone: _____ Relationship:_____

Current Employer:_____

How did you hear about us? (Please check one) ❑ Doctor (specify)_____ ❑ Social Media/Facebook

❑ Plymouth ENT Website ❑ Brochure

FOR TREATMENT IF A MINOR: AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned minor. I grant my authorization and consent to evaluate and treat my child for medical care.

Parent/ Legal Guardian Printed Name:_____

Parent/ Legal Guardian Signature:_____ Date: _____

Patient Demographics: Recent government mandates requires us to ask our patients about race, ethnicity, and preferred language. The decision to provide our practice with this information is voluntary.

Which of the following describes your race? ❑ White ❑ Hispanic ❑ Asian ❑ Black or African American

❑ American Indian or Alaskan Native ❑ Native Hawaiian or other Pacific Islander ❑ Other race

Which of the following describes your ethnicity? ❑ Non-Hispanic or Latino ❑ Hispanic or Latino ❑ Other

Do you have a preferred language preference? ❑ English ❑ Spanish ❑ Russian ❑ Indian ❑ Other

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MEDICAL HISTORY

Name:_____ DOB:_____

Height: _____ Weight: _____

Past Medical Illnesses: Please check any that apply.

❑ Diabetes	❑ Epilepsy	❑ HIV/AIDS	❑ Heart Problems	❑ Arthritis
❑ Stroke	❑ Migraines	❑ STD	❑ Mental Illness	❑ Varicose Veins
❑ Hay Fever	❑ Gallstones	❑ Ulcer	❑ Hypothyroid	❑ Kidney Stones
❑ Sexual Problem	❑ Hypertension	❑ Hepatitis	❑ Hyperthyroid	❑ Kidney Infection
❑ Autoimmune	❑ Parasites	❑ Phlebitis	❑ Bladder Problem	

❑ Cancer: Type? _____

Please Check if you have had one of the following: ❑ **Hepatitis** ❑ **MRSA** ❑ **Syphilis** ❑ **Gonorrhea** ❑ **CDIFF**

Are you currently experiencing any of the following? Please check any that apply.

❑ ENT	❑ Cardiovascular: Chest pain	❑ Neurological: Tremors
❑ Eyes: Double vision	❑ General: Fevers	❑ Musculoskeletal: Joint Pain
❑ Atrial Fibrillation	❑ Gastrointestinal: Heartburn	❑ Respiratory: Shortness of Breath
❑ Dizziness/ Vertigo	❑ Endocrine: Heat or Cold intolerance	
Sleep: ❑ Daytime Drowsiness	❑ Hematologic: Easy bruising	
❑ Snoring	❑ Integumentary: Rash	

Past Surgical Procedures: _____

Current Medications/mg/frequency:_____

Allergies to Medications: _____

Reason for today's appointment: _____

What have you done previously for this problem? _____ First Noted_____

Family History

Is there a history of cancer in your family? _____Type _____ Relationship _____

Is there a history of hearing loss? __

Do you currently smoke?_____ How long? _____ Packs per day? _____

Have you ever previously smoked? _____ How long? _____ Packs per day? _____

Release and Assignment

To my insurance carrier(s): This release and assignment form includes Medicare. I authorize the release of any medical information necessary to process this claim(s) and clarify that the above information is current and correct. I authorize payment of benefits to Plymouth ENT for services rendered.

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. A photocopy of this form may be used in lieu of the original.

Acknowledgement

I hereby acknowledge I have read and/or received a copy of the Privacy Notice of Plymouth ENT

Signature_____ Date _____

Plymouth Office: **30 Aldrin Road, Plymouth MA 02360, Phone: 508-746-8977, Fax: 508-746-3364**
Bourne Office: **1 County Road, Bourne, MA 02532, Phone: 508-759-0916, Fax: 508-759-0995**
Hyannis Office: **104 Park Street, Hyannis, MA 02601, Phone: 508-827-7692 Fax: 774-470-6534**
www.plymouthent.com

Notice of Privacy Practices

This note describes how medical information about you can be used and how to get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law. There are limitations upon to whom and under what circumstances your medical information can be disclosed. We do not share your private medical information with your spouse, parent, or employer unless you request it or unless required by law.

The law allows us to share your medical information with your insurance company in order to verify eligibility and that payment is appropriate for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who are treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request testing at a hospital, such as x-rays or laboratory testing. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however send you a reminder of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction of, as required by law, to the department of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of it upon request. There is a charge for copying depending on the number of pages involved. HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our privacy officer.

We will copy and send your record to another doctor if you request. We do not Fax your medical records (unless it is deemed by us to be a medical emergency). It is often more efficient if you hand-carry the copy yourself in order to ensure that it arrives on time, into the right hands.

** Signature_____ Date_____

I have read the above Privacy Practices.

Permission to Contact by Phone

I (PRINT NAME) _____ give permission to the offices of Plymouth, Nose and Throat to contact me by phone, and if necessary, leave messages regarding treatment and or appointments.

** Signature_____ Date_____

Financial Policy

This statement is to inform you of our policy. We are committed to providing you with the highest quality of medical care using only the best materials and technology available today. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative cost.

It is the responsibility of the patient to obtain a valid referral from their primary care physician by their contract with their insurance company. All patients that do not have a referral at the time of the visit will be accepting financial responsibility if one is not obtained or may need to reschedule the appointment until a valid referral is on file. All copayments are due at the time of service.

All commercial and uncontracted plans will be billed by this practice for one thirty day period as a courtesy. Any partial or unpaid balances after the thirty day period are the responsibility of the patient and are due upon receipt of the first statement. WE must emphasize that as your medical care provider, our relationship with you, NOT your insurance company.

Uninsured "self" patients will be asked to make an initial deposit of $200.00 at time services are rendered. Pricing and payment options can be arranged with our billing department.

This practice is not responsible for any non covered services provided and /or performed by outside laboratories or facilities. Our staff will attempt to use participating facilities; however, this is not always possible. Therefore, any billing related issues are directly between the patient and facility.

Today and all subsequent visits will be billed to your insurance company. Patients or responsible party signing below is responsible for all deductibles and all copayments for all visits.

I have read and understand the above terms listed on the financial policy. This agreement is valid for 3 years from signature date.

** Signature_____ Date_____

Appointment No Show Policy

We require at least 48 hours notice to cancel or reschedule any diagnostic testing taking place at Plymouth Ears, Nose and Throat or there will be a "No Show Fee" of $50.00 billed to the responsible party. This includes but is not limited to AVE, Allergy Testing, PH/Manometry, Fee and Strobe and Ultrasounds.

** Signature_____ Date_____