



**Southern New England Ear, Nose, Throat  
and Facial Plastic Surgery Group, LLP**  
(Head and Neck Surgery)

www.southernnewenglandent.com

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**Acknowledgment of Receipt of Notice of  
Privacy Practices**

Elizabeth Sullivan, Practice Manager  
203-777-7500

Name of Patient: \_\_\_\_\_

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

**HIPAA Questions**

As my doctor, you or your staff may:

**(PLEASE CHECK APPROPRIATE BOXES)**

- A.  Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member for me to call you back to schedule an appointment or to return your call.
- B.  Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member giving the results of a test.
- C.  Call my home and if necessary leave a message on the answering machine/voice mail/with a family member inquiring how I am doing.
- D.  Call my workplace and if necessary leave a message for me to call you back to schedule an appointment or just to return your call.

(The above instructions are valid for 12 months)

Signed: \_\_\_\_\_

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

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

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_

\_\_\_\_\_

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497 Main St. Ansonia CT 06401 (203) 734-9291 FAX (203) 732-4440	1157 Highland Ave. Cheshire CT 06410 (203) 271-1444 FAX (203) 699-9474	669 Boston Post Rd. Guilford CT 06437 (203) 458-6181 FAX (203) 458-6879	299 Washington Ave. Hamden CT 06518 (203) 288-3288 FAX (203) 230-0848	455 Lewis Ave. Meriden CT 06451 (203) 639-8154 FAX (203) 630-7084	51 South Main St. Middletown CT 06457 (860) 344-0055 FAX (860) 346-0199	247 Broad St. Milford CT 06460 (203) 877-6001 FAX (203) 882-0986
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**PATIENT IDENTIFICATION**

Mr.  Mrs.  Miss  Ms.

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ SEX: M F Age \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_  
Street City State Zip

EMAIL \_\_\_\_\_

TEL. (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_  
Area code

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ TEL. (\_\_\_\_\_) \_\_\_\_\_  
Street City State Zip Area code

SPOUSE'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

SPOUSE'S ADDRESS \_\_\_\_\_  
Street City State Zip

SPOUSE'S EMPLOYER \_\_\_\_\_ TEL. (\_\_\_\_\_) \_\_\_\_\_  
Area code

NEXT OF KIN NOT LIVING WITH YOU \_\_\_\_\_  
Name Address Tel.

**IF THE PATIENT IS A MINOR, STUDENT OR ANOTHER PARTY RESPONSIBLE FOR PAYMENT**

RESPONSIBLE PARTY (GUARANTOR/S) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_  
Area code Area code

**INSURANCE INFORMATION**

PRIMARY  MEDICARE  STATE WELFARE → IF YES, NAME OF INSURANCE \_\_\_\_\_

OTHER \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

I.D. # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_

SECONDARY  MEDICARE  STATE WELFARE → IF YES, NAME OF INSURANCE \_\_\_\_\_

OTHER \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

I.D. # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_

IS IT WORKMEN'S COMPENSATION? \_\_\_\_\_

IF YES — NAME OF YOUR COMPANY & CONTACT PERSON \_\_\_\_\_

REFERRING DOCTOR (IF ANY) \_\_\_\_\_  
Name Street City State

Primary Care Doctor \_\_\_\_\_

As a courtesy to you, our staff may, from time to time, complete and submit insurance forms. We do not charge you for performing these tasks and they are not part of the medical services we render to you. Accordingly, we cannot be responsible for errors or delay in the filling out and/or submission of insurance forms.

Regardless of any insurance coverage I/we may or may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance I/we agree to pay costs and attorney fees, as allowable by law and acknowledge receipt of a photocopy of this agreement.

SIGNATURE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Parent, Guardian, or responsible party

Authorization to release my medical records for billing purposes is granted by me.

SIGNATURE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Parent, Guardian, or responsible party

**\*\* PLEASE PRESENT WELFARE CARD AT TIME OF EACH VISIT \*\***

**SOUTHERN NEW ENGLAND EAR, NOSE, THROAT AND FACIAL PLASTIC SURGERY GROUP, LLP**

**PATIENT HISTORY**

DATE \_\_\_\_\_ CHART NUMBER \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

**ALLERGIES TO MEDICATIONS** \_\_\_\_\_

**PRIOR SERIOUS ILLNESS/MEDICAL CONDITIONS:**

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

**HOSPITALIZATIONS/SURGERY (give date & reason):**

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

**MEDICATIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

REFERRAL MD \_\_\_\_\_

OCCUPATION \_\_\_\_\_

SOCIAL HISTORY: Marital status: M\_\_ S\_\_ D\_\_ W\_\_

Cigarettes (packs/day) \_\_ Alcohol (drinks/day) \_\_\_\_\_

Recreational Drugs \_\_\_\_\_

**FAMILY HISTORY:** \_\_\_\_\_

**REVIEW OF SYSTEMS (check all):**

- |   |  |   |
|---|--|---|
| <p><b>Yes No 1. General</b></p> <p>___ weight loss</p> <p>___ weakness/fatigue</p> <p>___ fever/night sweats</p> <p><b>2. Eyes</b></p> <p>___ dryness/redness</p> <p>___ blurred/double vision</p> <p>___ glaucoma</p> <p><b>3. Heart &amp; Circulation</b></p> <p>___ chest pain</p> <p>___ irregular heartbeats</p> <p>___ heart murmur</p> <p>___ leg swelling</p> <p>___ high blood pressure</p> <p>___ rheumatic fever</p> <p><b>4. Lungs</b></p> <p>___ shortness of breath</p> <p>___ cough</p> <p>___ coughing up blood</p> <p>___ tuberculosis</p> <p>___ emphysema</p> <p>___ asthma</p> <p><b>5. Stomach &amp; Intestines</b></p> <p>___ nausea/vomiting/diarrhea</p> <p>___ heartburn</p> | <p><b>Yes No</b></p> <p>___ jaundice/hepatitis</p> <p>___ spitting up blood</p> <p>___ black stools</p> <p><b>6. Kidneys &amp; Genitals</b></p> <p>___ pain/burning on urination</p> <p>___ bloody/cloudy urine</p> <p>___ penile/vaginal discharge</p> <p>___ genital rash/ulcers</p> <p>___ venereal disease</p> <p>___ kidney stones</p> <p><b>7. Muscles &amp; Joints</b></p> <p>___ muscle weakness/pain</p> <p>___ joint pain/swelling</p> <p>___ arthritis/gout</p> <p><b>8. Skin &amp; Glands</b></p> <p>___ dryness</p> <p>___ rash</p> <p>___ growths/discoloration</p> <p>___ swollen glands</p> <p><b>9. Neurological</b></p> <p>___ headache</p> <p>___ numbness/weakness</p> <p>___ neuralgia</p> <p>___ off balance/dizziness</p> | <p><b>Yes No</b></p> <p>___ seizure</p> <p>___ stroke</p> <p>___ Bell's palsy</p> <p><b>10. Psychiatric</b></p> <p>___ anxiety</p> <p>___ depression</p> <p>___ delusions/hallucinations</p> <p>___ medications</p> <p><b>11. Hormones</b></p> <p>___ thyroid disorder</p> <p>___ diabetes ("sugar")</p> <p>___ irregular menses</p> <p><b>12. Blood</b></p> <p>___ bleeding tendency</p> <p>___ easy bruising</p> <p>___ anemia</p> <p><b>13. Immune System</b></p> <p>___ frequent infections</p> <p>___ positive HIV test</p> <p><b>14. If Child</b></p> <p>___ immunizations up to date</p> <p>___ feeding difficulties</p> |
|---|--|---|

The information is to the best of my knowledge accurate and complete. PATIENT SIGNATURE \_\_\_\_\_

Reviewed and updated. PHYSICIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_