



**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) 737-4440	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 _____ Last First Middle SEX: M F Age _____

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

PATIENT HISTORY

DATE _____ CHART NO. _____

NAME _____ DATE OF BIRTH _____ AGE _____

ALLERGIES TO MEDICATIONS: _____

MEDICATIONS

- 1. _____ REFERRAL M.D. _____
- 2. _____ OCCUPATION _____
- 3. _____ SOCIAL HISTORY: Marital status: M ___ S ___ D ___ W ___
- 4. _____ Cigarettes (packs/day) _____ Alcohol (drinks/day) _____
- 5. _____ Recreational Drugs _____

PRIOR SERIOUS ILLNESS / MEDICAL CONDITIONS:

Pertinent Medical History about your Family

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

HOSPITALIZATIONS / SURGERY (give date and reason):

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

REVIEW OF SYSTEMS (check all):

Yes No

1. General

- ___ weight loss
- ___ weakness / fatigue
- ___ fever / night sweats

2. Eyes:

- ___ dryness / redness
- ___ blurred / double vision
- ___ glaucoma

3. Heart and Circulation:

- ___ chest pain
- ___ irregular heartbeats
- ___ heart murmur
- ___ leg swelling
- ___ high blood pressure
- ___ rheumatic fever

4. Lungs:

- ___ shortness of breath
- ___ cough
- ___ coughing up blood
- ___ tuberculosis
- ___ emphysema
- ___ asthma

5. Stomach and Intestines:

- ___ nausea / vomiting / diarrhea
- ___ heartburn / reflux

Yes No

- ___ jaundice/hepatitis
- ___ spitting up blood
- ___ black stools

6. Kidneys and Genitals:

- ___ pain / burning on urination
- ___ bloody / cloudy urine
- ___ penile / vaginal discharge
- ___ genital rash / ulcers
- ___ venereal disease
- ___ kidney stones

7. Muscles and Joints:

- ___ muscle weakness / pain
- ___ joint pain / swelling
- ___ arthritis / gout

8. Skin and Glands:

- ___ dryness
- ___ rash
- ___ growths / discoloration
- ___ swollen glands

9. Neurological:

- ___ headache
- ___ numbness / weakness
- ___ neuralgia
- ___ off balance / dizziness

Yes No

- ___ seizure
- ___ stroke
- ___ Bell's palsy

10. Psychiatric:

- ___ anxiety
- ___ depression
- ___ delusions / hallucinations
- ___ medications

11. Hormones:

- ___ thyroid disorder
- ___ diabetes ("sugar")
- ___ irregular menses

12. Blood:

- ___ bleeding tendency
- ___ easy bruising
- ___ anemia

13. Immune System:

- ___ frequent infections
- ___ positive HIV test

14. If Child:

- ___ immunization up to date
- ___ feeding difficulties

The information is to the best of my knowledge accurate and complete. PATIENT SIGNATURE: _____

Reviewed and updated. PHYSICIAN SIGNATURE: _____