Southern New England
Ear, Nose, Throat & Facial Plastic Surgery Group LLP

PATIENT IDENTIFICATION ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. **DATE**_____

Patient's Name:	Last	First	MI
Address:	Street City State		Zip code
Email:		DOB:	
Home Phone:	Cell Phone:	Work Phone:	
Sex: ☐ M ☐F	Race: ☐American Indian/Alaska Native ☐Asian ☐Black/Africa American ☐Native Hawaiian/other Pac Islander ☐ White		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	Language:	SS#	
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated			
Employer:		Your Occupation:	
Spouse's Name:		DOB:	
Spouse's Address:			
Spouse's Employer:		Phone:	
Emergency Contact:	Name Address Phone#		
Pharmacy: Name Address (street, city, state, zip) Phone#			

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

Responsible Party/Guarantor(s):		Relationship:
Address:		DOB:
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION

Primary: ☐Medicare ☐State Welfare ☐Other Insurance		Name of Insured:
ID#	Group#	DOB:
Secondary: ☐Medicare ☐State Welfare ☐Other Insurance		Name of Insured:
ID#	Group#	DOB:
Is it Worker's Compensation?		
If yes, name of your company & contact person:		
Referring Doctor:	Name Address Phone# Fax #	
Primary Care Doctor:	Name Address Phone# Fax #	

If we participate with your insurance company we will submit your claim to them, but we cannot be responsible for errors or delay in the filling out and/or submission of insurance forms if we do not have the proper insurance card.

Regardless of any insurance coverage I/we 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 INSURANCE CARD AT THE TIME OF EACH VISIT***** 1/14/2021

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PATIENT HISTORY DATE_____ CHART #_____

NAME_____ DATE OF BIRTH_____ AGE_____

SOCIAL HISTORY: Marital status: M____ S____ D____ W____ Alcohol (drinks/day)_____

Cigarettes (packs/day) _____ Were you ever a smoker? (circle) Yes /No Recreational Drugs_____

PRIOR SERIOUS ILLNESSES/MEDICAL CONDITIONS: **FAMILY – PERTINENT MEDICAL HISTORY**

1.	5.	1.	5.
2.	6.	2.	6.
3.	7.	3.	7.
4.	8.	4.	8.

HOSPITALIZATIONS/SURGERY (give date and reason):

CURRENT MEDICATIONS YOU ARE TAKING:

ALLERGIES TO MEDICATIONS:

REVIEW OF SYSTEMS (check all):

Yes	No	**1. Allergic / Immunologic**
		Frequent Infections
		Positive HIV test
Yes	No	**2.Cardiovascular**
		Chest pain
		Heart murmur
		High blood pressure
		Irregular heartbeats
		Leg swelling
		Low blood pressure
		Rheumatic fever
Yes	No	**3. Constitution**
		Fever / night sweats
		Weakness / fatigue
		Weight loss
Yes	No	**4. Endocrine**
		Diabetes (“sugar”)
		Irregular menses
		Thyroid disorder
Yes	No	**5. Eyes**
		Blurred / double vision
		Cataracts
		Dryness / redness
		Glaucoma
		Itchy
		Macular degeneration
		Watery

Yes	No	**6. Gastrointestinal**
		Black stools
		Crohn’s disease
		Heartburn / reflux
		IBS
		Jaundice / hepatitis
		Nausea / vomiting / diarrhea
		Spitting up blood
Yes	No	**7. Genitourinary**
		Bloody / cloudy urine
		Frequent urination
		Genital rash / ulcers
		Kidney disease
		Kidney stones
		Pain / burning on urination
		Penile / vaginal discharge
		Venereal disease
Yes	No	**8. Hematologic / lymphatic**
		Anemia
		Bleeding tendency
		Easy bruising
		Thalassemia
Yes	No	**9. Integumentary (skin)**
		Dryness
		Eczema
		Growths / discoloration
		Rash
		Rosacea
		Swollen glands

Yes	No	**10. Musculoskeletal**
		Muscle weakness / pain
		Joint pain / swelling
		Arthritis / gout
Yes	No	**11. Neurological**
		Bell’s palsy
		Headache
		Neuralgia
		Numbness / weakness
		Off balance / dizziness
		Seizure
		Stroke
Yes	No	**12. Psychiatric**
		Anxiety
		Delusions / hallucinations
		Depression
		Medications
Yes	No	**13. Respiratory**
		Asthma
		COPD
		Cough
		Coughing of blood
		Emphysema
		Shortness of breath
		Tuberculosis
Yes	No	**14. If Child:**
		Immunizations up to date
		Feeding difficulties

The information is to the best of my knowledge accurate & complete. PATIENT SIGNATURE:_____ (rev 1/14/21)

Southern New England Ear, Nose, Throat and Facial Plastic Surgery Group, LLP
(Head and Neck Surgery)
www.southernnewenglandent.com

Ken Yanagisawa, MD, FACS, LLC
(203) 787-4244 - *Managing Partner*

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Kathy Ngo, MPAS, PA-C
(203) 684-1109

Mary-Kate Morrison, MPAS, PA-C
(203) 777-3944

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 ALL 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.

E. ☐ **WARNING REGARDING HIPAA AND EMAIL/TEXT COMMUNICATIONS**
The Practice takes every step possible to maintain your privacy and to stay compliant with all HIPAA laws. However, at this time in technology, it is not possible to ensure complete privacy between you and our practice for email and text communications. In other words, if you are to text or email any of your medical information or photos to our practice it cannot be guaranteed that all of the information is compliant with HIPAA privacy laws and it is possible that some of it could be inadvertently exposed. For this reason, we want to make clear that HIPAA compliance is not possible for all text and emails between you and either your provider or any of the SNEENT staff and you should be warned of the possibility of sensitive information being unprotected. Your signature below memorializes your understanding of this important issue.

(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:_____

1/14/2021

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~ Welcome to Southern New England ENT & FPS Group ! ~

Thank you for choosing our practice for your ear, nose, and throat medical/surgical care. Our physicians, PA's, and staff will provide you with caring attention and professional healthcare.

INSURANCE and CREDIT CARDS

We accept insurance assignment for your visits, and recognize that many of the commercial insurance plans have a high deductible causing a large balance on your account. In order to increase our efficiency, we **require a credit card at the time of check-in**, to cover these high deductibles **(NOT applicable to Medicare or Medicaid patients).**

The information will be held in a completely secure area until it is determined what your balance is. It can take up to 2-3 weeks before we receive an insurance Explanation of Benefits (EOB). Once received, we will call you for permission to use your credit card. If you are not at home we will leave a message for you to call us back. If we do not hear from you in two (2) business days, we will proceed with payment processing on your credit card, and will send you a copy of the credit card authorization and the EOB. Your signature below allows us to proceed as outlined.

Rest assured that we take every safety precaution to protect your information in a locked and secure location with NO online or computer exposure. This avoids the inconvenience of mail-in payments or calling in credit card numbers. We will still expect co-payments at the time of your visit.

Signature: _____

Printed Name/Relation: _____

Date: _____

1/14/2021

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APPOINTMENT CANCELLATION and NO SHOW POLICY AGREEMENT

If you cannot make your scheduled appointment for any reason, please call our Scheduling Department at **203-787-4951** at least **24 hours** before your scheduled appointment to cancel or reschedule. There will be a **$25.00** charge for missing an appointment without a 24 hour notification call.

Patients that **NO SHOW** (do not provide a notification call to cancel) three (3) or more times in a 12 month period may be dismissed from the practice and will be denied any future appointments.

Thank you for your cooperation and understanding. Please sign below that you agree to these terms.

Signature: _____

Printed Name/Relation: _____

Date: _____

Main Office: ***One Long Wharf Drive, Suite 302, New Haven, CT 06511*** Clinical Fax (203) 776-7741 • ADM Fax (203) 777-8469

497 Main St
Ansonia CT 06401
(203) 734-9291
Fax (203) 732-4440

288 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

233 Broad St
Milford CT 06460
(203) 877-6001
Fax (203) 882-0986