



*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*

Ronald H. Hirokawa, MD, FACS, PC
(203) 865-6391

Eaton Chen, MD, MPH, FACS, LLC
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Maria N. Byrne, MD, FACS, LLC
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Howard Patrick Boey, MD, FACS, PC
(203) 777-0188

Mark A. D'Agostino, MD, FACS, LLC
(203) 776-1288

Tiffany Chen, MD
(203) 872-4709

Samantha Almeida, MHS, PA-C
(203) 624-9465

Heide Kalra, MPAS, PA-C
(203) 800-8090

~ 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: _____

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

1157 Highland Ave
Cheshire CT 06410
(203) 271-1444
Fax (203) 669-9474

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



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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: _____

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Fax (203) 882-0986

Patient's Name:		Last		First		MI				
Address:		Street		City		State		Zip code		
Email:						DOB:				
Home Phone:			Cell Phone:			Work Phone:				
Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/Africa American <input type="checkbox"/> Native Hawaiian/other Pac Islander <input type="checkbox"/> White								
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown				Language:			SS#			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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: <input type="checkbox"/> Medicare <input type="checkbox"/> State Welfare <input type="checkbox"/> Other Insurance						Name of Insured:				
ID#		Group#			DOB:					
Secondary: <input type="checkbox"/> Medicare <input type="checkbox"/> State Welfare <input type="checkbox"/> 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										

PATIENT HISTORY

DATE _____ CHART # _____

NAME _____ DATE OF BIRTH _____ AGE _____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATIONS YOU ARE TAKING:

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 ILLNESSES/MEDICAL CONDITIONS: Pertinent Medical History about your Family

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ | <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ |
|--|--|

HOSPITALIZATIONS/SURGERY (give date and reason):

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

REVIEW OF SYSTEMS (check all):

Yes	No	
1. Allergic / Immunologic		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections
<input type="checkbox"/>	<input type="checkbox"/>	Positive HIV test
2. Cardiovascular		
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeats
<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
3. Constitution		
<input type="checkbox"/>	<input type="checkbox"/>	Fever / night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Weakness / fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
4. Endocrine		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes ("sugar")
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menses
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder
5. Eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Blurred / double vision
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Dryness / redness
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Itchy
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Watery
6. Gastrointestinal		
<input type="checkbox"/>	<input type="checkbox"/>	Black stools
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / reflux
<input type="checkbox"/>	<input type="checkbox"/>	IBS
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice / hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting / diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood
7. Genitourinary		
<input type="checkbox"/>	<input type="checkbox"/>	Bloody / cloudy urine
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Genital rash / ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Pain / burning on urination
<input type="checkbox"/>	<input type="checkbox"/>	Penile / vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
8. Hematologic / lymphatic		
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia
9. Integumentary (skin)		
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Growths / discoloration
<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Rosacea
<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands
10. Musculoskeletal		
<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness / pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain / swelling
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / gout
11. Neurological		
<input type="checkbox"/>	<input type="checkbox"/>	Bell's palsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	Numbness / weakness
<input type="checkbox"/>	<input type="checkbox"/>	Off balance / dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Seizure
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
12. Psychiatric		
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Delusions / hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Medications
13. Respiratory		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	COPD
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing of blood
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
14. If Child:		
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date
<input type="checkbox"/>	<input type="checkbox"/>	Feeding difficulties

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

Reviewed and updated. PHYSICIAN SIGNATURE: _____



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Acknowledgment of Receipt of Notice of Privacy Practices

Elizabeth Sullivan, Practice Manager phone: 203-777-7500

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

HIPAA Questions

(PLEASE CHECK ALL APPROPRIATE BOXES) (Instructions valid for 12 months) As my doctor, you or your staff may:

- 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.

***HEALTH PLAN REQUIREMENTS.** I am responsible for knowing my medical policy and am responsible for any charges if any of the following apply:

- My health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Southern New England Ear, Nose, Throat and Facial Plastic Surgery Group, LLP (SNEENT), and I have not obtained an appropriate and accurate authorization or referral;
- I receive services in excess of such authorization or referral;
- My health plan determines that the services I received at SNEENT are not medically necessary and/or not covered by my insurance plan;
- My health plan coverage has lapsed or expired at the time I received services at SNEENT;
- I have chosen not to use my health plan coverage.

**I agree with all the above terms.

Signature: _____ Printed Name/Relation: _____ Date: _____

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