Patient's Name (last, first, middle initial)_____

Patient's Address:_____

(Please include Zip Code)_____ Email Address: _____

Home Phone: ( )_____ Work Phone: ( )_____

Social Security Number of Patient: _____

Date of Birth of Patient: _____
Month Day Year

Sex of Patient: Male Female

Referred By: _____ Family Doctor: _____

Marriage Status: Single Married Widowed Divorced

Your pharmacy name: _____ Pharmacy town: _____

Pharmacy Street_____

Preferred Language (please circle or fill in) English Spanish Other_____

Ethnicity (requested by US Government, please check one): O Hispanic or Latino O Not Hispanic or Latino
O I decline to be classified

Race (requested by US Government, please check one): O White O Black or African American O Hispanic
O Asian O American Indian or Alaskan Native O other O Hispanic White O Hispanic Black
O Pacific Islander or Native Hawaiian O I decline to be classified

---

EMERGENCY INFORMATION

Name of Person to Call: _____

Relationship to patient: _____
(ie. Wife, father, etc.)

Home Telephone: ( )_____

Work Telephone: ( ) _____

Place of Employment of Emergency Contact: _____

Name of **PRIMARY** Insurance Company:_____

Membership/Employee Number:_____

Employer: _____ Is Employer listed on insurance card? Y/N

Group Number (if listed on insurance card):_____

Relationship of patient to person
named on insurance card: Self Spouse Child Other _____

Name of **SECONDARY** Insurance Company: _____
(ie. Medigap. If you do not have secondary insurance leave this section blank).

Membership/Employee Number: _____

Employer: _____ Is Employer listed on insurance card? Y/N

Group Number (if listed on insurance card):_____

Relationship of patient to person
named on insurance card: Self Spouse Child Other _____

PLEASE FILL OUT THIS PAGE ONLY IF:

1) THE PARTY RESPONSIBLE FOR THE BILL IS NOT THE PATIENT.
(ie. If the patient is a child on a parent's insurance policy)

OR

2) THE INSURANCE POLICY IS NOT IN NAME OF THE PATIENT.

(ie. If the patient is insured on the policy of a spouse)

Name of the person named on insurance card or person responsible for bill.

_____

Last First Middle Initial

Address of person named on insurance card or person responsible for bill.
(Please include ZIP code. If same as patient's address, write SAME).

_____

_____

Home phone of person named on insurance card or person responsible for bill. (If same as patient's, write SAME). (____)_____

Work phone of person named on insurance card or person responsible for bill. (If same as patient's, write SAME). (____)_____

Social Security Number of person named on insurance card or person responsible for bill: _____

Date of Birth of person named on insurance card or person responsible for bill: _____
Month Day Year

Sex of person named on insurance card
Or person responsible for bill: Male Female

Marriage status of person named on insurance card
or person responsible for bill: Single Married Widowed Divorced

Patient Name_____Date initially completed_____ PAGE 1/ 2
PMH/AH/FH = 1 element each, level 1-3 -> 1 element level 4-5 -> 3 elements

PATIENTS PLEASE COMPLETE UNSHADED AREAS ON <u>BOTH</u> SIDES OF THIS FORM

MEDICATIONS
Is the patient taking any medications? Yes No
If yes, which ones? What dose? How often? _____

_____

ALLERGIES
Is the patient allergic to any drugs? Yes No
If yes, which ones? _____ What happened? _____

Is the patient allergic to anything else? Yes No
If yes, what? _____ What happened? _____

REVIEW OF SYSTEMS *level 2 -> 1 system level 3 -> 2-9 systems level 4-5 10 or more systems*
Circle any symptoms/conditions that the patient has had recently/chronically

O check here if none of below items apply

constitutional:	fever	chills	sweats	fatigue		
respiratory:	cough	short of breath	coughing up blood			
skin:	rashes	itching	sores	skin changes		
psychiatric:	anxiety	depression				
eye:	blurred vision	itching eyes	double vision	eye pain	dryness	tearing
gastrointestinal:	constipation	heartburn	diarrhea	vomiting	belching	
neurologic:	seizures	headache				
allergic/immunologic:		sneezing				
ear/nose/throat:						
	hearing loss	noise in ears	ear discharge	earache		
	itchy ears	dizziness				
	ear lesions					
	loss of sense of smell	nose bleeds	nasal discharge	nasal congestion		
	post-nasal drip	nasal lesions				
	bleeding gums	oral sores	dry mouth	mouth pain		
	bad breath	loss of sense of taste				
	sore throat	hoarseness				
	problems swallowing	snoring				
	lumps in the neck					
	unclear speech					
genitourinary:	painful urination	blood in urine				
endocrine:	weight loss	weight gain	intolerance to heat	intolerance to cold		
cardiovascular:	palpitations	swollen ankles	chest pain			
musculoskeletal:	muscle aches					
lymphatic/hematologic:	easy bruising	easy bleeding	bone pain			

PAST MEDICAL HISTORY
Has the patient ever had:

Diabetes	Yes No	High Blood Pressure	Yes No	Kidney Disease	Yes No
Heart Disease	Yes No	Thyroid Problems	Yes No	Lung Problems	Yes No
Gastrointestinal Problems	Yes No			Neurologic Problems	Yes No

SURGERY AND HOSPITALIZATION
Has the patient ever had surgery? Yes No
If yes, what kind of operation, what for? _____

_____

Has the patient ever been hospitalized for reasons other than surgery? Yes No
If yes, what for, what year? _____

_____

FAMILY HISTORY (List any affected relatives – i.e. father, sister, grandmother, aunt etc.)

Heart Disease	Yes No _____	Bleeding Problems	Yes No _____
Allergies	Yes No _____	Anesthesia Problems	Yes No _____
Asthma	Yes No _____	High Blood Pressure	Yes No _____
Diabetes	Yes No _____	Hearing Loss	Yes No _____

SOCIAL/PERSONAL HISTORY
What is the patient's occupation? _____
Does the patient consume alcohol beverages? Yes No
If yes, how much on average per day?
_____ bottles of beer/day _____drinks of liquor/day _____glasses of wine/day
Does the patient use tobacco products currently? Yes No
If the patient has ever used tobacco products, what type? (please circle those that apply)
Cigarettes, cigars, pipe, chewing
Amount per day on average?
_____ packs of cigarettes, cigars, pipe bowls, chewing packs (please circle those that apply)
For how many years? _____
What year did the patient quit? _____

_____, M.D.
PHYSICIAN SIGNATURE

Greenwich Ear, Nose & Throat
Head & Neck Surgery
49 Lake Avenue, Suite 103
Greenwich, CT 06830
Phone: (203) 869-2030
Fax: (203) 869-9262

Stamford Ear, Nose & Throat
Head & Neck Surgery
125 Strawberry Hill Avenue, Suite 103
Stamford, CT 06902
Phone: (203) 348-7797
Fax: (203) 964-3140

Ear Nose & Throat - Head & Neck Surgery
Stephen J. Salzer, M.D.
Steven Bramwit, M.D.
Michelle S. Marrinan, M.D.
Elise Cheng, M.D.
Audiology & Hearing Aids
Perry Lerner, Au.D., FAAA
Jablonski, Joshua, Au.D.

AUTHORIZATION FORM

PLEASE READ CAREFULLY BEFORE SIGNING

NAME OF PATIENT: _____ DATE_____

HEALTH INSURANCE NUMBER: _____

SUBSCRIPTION IDENTIFICATION, MEMBERSHIP NUMBER, ETC.: _____

_____

- I request that payment of authorized benefits be made on my behalf to Greenwich Ear, Nose & Throat - Head & Neck Surgery, P.C. (GENT, P.C.) for any services furnished.
- I authorize any holder of medical information about me to release to my insurance company, its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services; and to the State Attorney General, Insurance Commissioner, Managed Care Ombudsmen and other governmental agencies.
- I have received information regarding the providers of care in this organization, the Patient's Bill of Rights and Responsibilities, and information regarding the grievance process.
- I understand that it is my responsibility to obtain any necessary referral.
- **I understand that if I am seen without a referral from my primary care physician and my health plan requires a referral, then my health plan may not cover the charges for my care from GENT, P.C. In that case, I will be responsible for my bill.**
- A list of plans with which each provider participates is available at the front desk, and I know that I may review this list before being seen, and use this information to determine if I wish to be treated by a GENT, P.C. provider. I am aware that GENT, P.C. providers do not participate with state Medicaid. If I do not have insurance, or if my provider does not participate with my insurance, then I agree to be responsible for my bill, and I know that I may be required to pay my bill at the time of service.
- I understand that hearing aids, hearing aid adjustments and hearing aid repairs are not covered by many insurance plans and I agree to pay for these services myself.
- I understand that many insurance plans will not pay for services such as ear wax removal, hearing tests or other procedures on the same day as an office visit. I accept that it is my responsibility to know the details of my own insurance and will notify my doctor if my insurance has such a policy. In that case, I will be given the opportunity to return on a different day for any required additional service or procedure. If I do not notify the doctor of this requirement, or if I decide to have more services on one day than my insurance allows, then I will be responsible for paying any service not covered by my insurance.
- If I am the parent or legal guardian of the patient, I authorize evaluation and treatment by the doctors and staff.

_____
Signature – Patient or Authorized Party

Greenwich Ear, Nose and Throat- Head and Neck Surgery Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR PRIVACY OFFICEE AT THE ADDRESS AND PHONE NUMBER AT THE BOTTOM OF THIS NOTICE.

WHO WILL FOLLOW THIS NOTICE?

Greenwich Ear, Nose and Throat- Head and Neck Surgery facilities provide healthcare to our patients, residents and clients in partnership with physicians and other professionals and organizations. The information privacy practices I this notice will be followed by:

- Any healthcare professional who treats you at any of our locations.
- All departments and units of our organization, including Greenwich Ear, Nose and Throat- Head and Neck Surgery
- All employees, medical staff, trainees, students, or volunteers of the entities listed above.
- Each of our facilities and affiliates may share your health information for coordination of care, treatment, payment and healthcare operation purposes.

OUR PLEDGE TO YOU:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers above. We are required by law to:

- Keep medical information about you private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU?

- We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) this includes psychiatric or HIV treatment information if needed for purposes of your diagnosis and treatment; to obtain payment or treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods for professional education purposes). NOTICE: only limited psychiatric or HIV information may be disclosed for billing purposes with out your authorization.
- Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about recommending possible treatment options, alternatives, health- related benefits or services that may be of interest to you.
- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you without your prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, worker's compensation purposes, emergencies, national security and other specialized government functions and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to valid judicial or administrative orders or other legal process. Under certain circumstances, we may use and disclose health information about you for research to review information that may help them prepare for research, as long as the health information they review doesn't leave our facility and as long as they agree to specific privacy protections.
- We may disclose medical information about you to a friend or family member whom you have designated or in appropriate circumstances, unless you requested a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

OTHER USES IN MEDICAL INFORMATION:

In any other situation not covered in this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclose, you can later revoke that authorization by notifying us in writing of your decision.

RIGHT TO ACCESS AND OR AMEND YOUR RECORDS:

- In most case you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that provides your reason for requesting the amendment. We could deny your request to mend a record if we determine that record is accurate, you may submit a written request for a review of that decision.

RIGHT TO AN ACCOUNTING:

- You have to right to request a list accounting for any disclosure of your health information we have made, except for uses and disclosures, for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain exceptions.
- To request this list of disclosures, indicate the relevant period which must be after April 14, 2003, but in no event for more than the last six years. You must submit your request to Office Manager, GENT- Head and Neck Surgery, 49 Lake Ave, Greenwich CT 06830.

RIGHT TO REQUEST RESTRICTIONS:

- You may request, in writing, that we do not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it.
- We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our offices.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS:

You have the right to request that medical information about you to be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

RIGHT TO REQUEST A PAPER COPY OF THIS NOTICE:

You may request a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

CHANGES TO THIS NOTICE:

We may change our policies at any time. Change will apply to medical information we already hold, as well as new information after the change occurs. You can receive a copy of the current notice at any time. The effective date listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

COMPLAINTS:

- If you are concerned that your privacy rights may have been violated or you disagree with a decision we made about access to your records, you may contact our office.
- If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our office can provide you the address. Under no circumstances will you be penalized or realized for filling a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Version effective 4-14-2003

_____ Date:_____

(Print name of patient)

_____

(Signature of patient or guardian)