LIBERTY ENT ASSOCIATES, LLC
JOHN L. SAPORITO, MD

Patient Information

First Name:______________________ Middle Initial:__________ Last Name:______________________

Email:______________________________ SS#:__________________ DOB:________________

Phone#:__________________ Work#:____________________ Cell#:______________________

Address:______________________________ City:__________________ State:________ Zip:__________

Patient Age:______ **Patient Height:**________ **Patient Weight:**________ Marital Status: ❑S ❑M ❑D ❑W Sex: ❑M ❑F

Referring Doctor/Primary Doctor:_____________________________ Phone:______________________

Address:____
(Street) (City) (State) (Zip)

Pharmacy:____ Phone:______________________

Address:____
(Street) (City) (State)

Employer (or Parent/Guardian Employer):________________________ Phone:______________________

Address:____
(Street) (City) (State)

Emergency Contact:__________________ Relationship:____________ Phone:__________________

Parent/Guardian of Child:____________________ DOB:____________ Phone:__________________

How did you hear about us? ❑Returning Patient ❑Friend/Family ❑Internet ❑Doctor Referral__________ ❑Other________

Insurance Information

Name of Insured Subscriber:____________________ SS#:________________ DOB:____________

Insurance Company:___________________________________ Phone:______________________

Address:____
(Street) (City) (State)

Group#:______________________ ID#____

Secondary Insurance Company:__________________________ Phone:______________________

Name of Insured Subscriber:________________ Employer:________________ Phone#:____________

Subscriber DOB:__________________ Group#:________________ ID#______________________

Workers Compensation:____

PLEASE NOTE: INSURANCE CONTRACTS ARE MADE BETWEEN YOU AND THE INSURANCE COMPANY. WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. PAYMENT OF ANY CHARGES ARE PRESUMED TO BE YOUR RESPONSIBILITY.

I HEREBY AUTHORIZE LIBERTY ENT ASSOCIATES, LLC TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO MY INSURANCE COMPANY, ATTORNEY, SCHOOL, OR OTHER TREATING PHYSICIAN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I UNDERSTAND THAT LIBERTY ENT ASSOCIATES, LLC REQUIRES PAYMENT AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN AGREED UPON.

Signature of Responsible Party:______________________________ **Date:**________________

Name:______________________________________
(Print Name)

... Thank you for completing the entire form.

LIBERTY ENT ASSOCIATES, LLC
JOHN L. SAPORITO, MD

Office Policy - Patient Responsibility

Patient Name____ **DOB**:____________________
(please print)

I understand that it is my responsibility to know my insurance policy regarding doctor participation, referrals, and what is covered by my insurance company.

I understand that additional charges will be incurred for procedures performed by the doctor at the time of my visit.

I understand that if I require surgery, it is my responsibility to get any necessary referrals, if needed, and to also call my insurance company to see what my responsibilities are.

I understand that if my insurance company requires a referral, and I do not have one, I am responsible for full payment at the time of my visit.

I understand that referrals will not be accepted after the time of my visit.

I understand that insurance contracts are made between me and the insurance company.

I understand that I am responsible for any amount not covered by insurance.

Liberty ENT Associates, LLC does not render services on the assumption that the charges will be paid by my insurance company. Payment of any charges are presumed to be my responsibility.

I hereby authorize Liberty ENT Associates, LLC to furnish information concerning my illness and treatment to my insurance company, attorney, school, or other treating physician.

I understand that Liberty ENT Associates, LLC require payment at the time of treatment unless prior arrangements have been agreed upon.

I understand that there will be a $25.00 charge for all returned checks.

I understand I will be responsible for all collection and attorney fees should my account be referred to a collection agency.

Signature of Responsible Party:____________________________________ **Date**:_______________
Person who brings in patient, if patient is a minor, is responsible for payment.

ATTENTION:

IF YOU HAVE ANY CHANGES IN YOUR INSURANCE COVERAGE, PLEASE PROVIDE US WITH THIS INFORMATION SO WE MAY UPDATE OUR RECORDS.

IF COVERAGE HAS CHANGED AND WE ARE NOT AWARE OF THIS CHANGE, YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES.

Signature of Responsible Party:____________________________________ **Date**:_______________

LIBERTY ENT ASSOCIATES, LLC

JOHN L. SAPORITO, MD

Acknowledgment of Receipt of Privacy Practices

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

Name of Patient: ______________________________ **DOB**:____________________

Please list anyone that you give your permission to have your Protected Health Information:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's Protected Health Information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I also authorize the release of "my results", such as laboratory results, X-ray results, clinical findings of consultations and the like, by phone or fax to following number______________________________

This information may also be left on the answering machine at the same phone number: ❑Yes ❑ No

Signature of Patient or Personal Representative:______________________________ **Date**:____________

If signed by personal representative, relationship to patient:______________________________

OFFICIAL USE ONLY

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained, or practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

❑Refused to sign ❑Physically unable to sign ❑(Other):______________________________

Employee Name:______________________________ Date:____________________

Employee Signature:______________________________

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Patient Name________________________________ **Date of Birth**______________ **Age**____________

General Medical History

1) **Reason for visit**____

2) **FEMALE PATIENTS**

Are you currently pregnant?	❑ YES	❑ NO
Attempting to become pregnant?	❑ YES	❑ NO
Are you currently breast-feeding?	❑ YES	❑ NO

3) **Patient Medical History**
Do you or have you had?

	YES	NO		YES	NO
Diabetes	❑	❑	Lung Problems	❑	❑
High Blood Pressure	❑	❑	Kidney Disease	❑	❑
Heart Problems	❑	❑	Gout	❑	❑
Stroke	❑	❑	Stomach Problems	❑	❑
Rheumatic Fever	❑	❑	Gallbladder Problems	❑	❑
Anemia	❑	❑	Colitis	❑	❑
Regional Enteritis	❑	❑	Crohn's Disease	❑	❑
Jaundice	❑	❑	Thyroid Disease	❑	❑
Hormone Therapy	❑	❑	Cancer	❑	❑
Diverticulosis	❑	❑	Chemotherapy	❑	❑
Hepatitis	❑	❑	Radiation Therapy	❑	❑

When was your last tetanus vaccine?
❑ Less than 10 years ago
❑ More than 10 years ago

If you are over 65, have you received the pneumonia vaccine?
❑ YES ❑ NO

Do you receive yearly flu shots?
❑ YES ❑ NO

4) **List all drug allergies**____

5) **Do you have a latex allergy?** ❑ YES ❑ NO

6) **List all current medications** ____________________________________
____

Past Surgical History:
____
____

Family History: *Please list disease or illness prevalent in family*
____
____

Social History

Use of Alcohol	❑ Never	❑ Rarely	❑ Moderate	❑ Daily
Use of Tobacco	❑ Never	❑ Previously, but quit	❑ Current packs/per day__________	

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Patient Name________________________ **Date of Birth**______________

Please answer the following questions:

Date of last physical examination: ______________________________

CONSTITUTIONAL	YES	NO
Good health generally	❑	❑
Weight loss	❑	❑
Weight gain	❑	❑
Night Sweats	❑	❑
Excessive sleepiness	❑	❑

CARDIOVASCULAR	YES	NO
Chest Pain	❑	❑
Palpitations	❑	❑

GENITOURINARY	YES	NO
Painful or frequent urination	❑	❑
Venereal disease (VD)	❑	❑
Venereal warts	❑	❑
Kidney Stones	❑	❑

NEUROLOGICAL	YES	NO
Weakness in arms or legs	❑	❑
Changes in coordination	❑	❑
Changes in balance	❑	❑
Shaking or tremors	❑	❑
Loss of consciousness	❑	❑
Passing out	❑	❑
Seizures or fits	❑	❑
Headaches	❑	❑
Numbness	❑	❑

GASTROINTESTINAL	YES	NO
Nausea or vomiting	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Vomiting blood	❑	❑

MUSCULOSKELETAL	YES	NO
Bone or joint pain	❑	❑
Muscle pain	❑	❑
Muscle weakness	❑	❑

EARS	YES	NO
Hearing loss	❑	❑
Left ear	❑	❑
Right ear	❑	❑
Dizziness	❑	❑
Spinning	❑	❑
Imbalance	❑	❑
Lightheadedness	❑	❑
Pain	❑	❑
Left	❑	❑
Right	❑	❑

EYES	YES	NO
Blurred or double vision	❑	❑
Excess tearing	❑	❑

THROAT	YES	NO
Difficulty	❑	❑
swallowing	❑	❑
Hoarseness	❑	❑
Sore Throat	❑	❑
Pharyngitis		

NECK	YES	NO
Swelling	❑	❑
Masses/lumps	❑	❑
Tenderness/pain	❑	❑

SKIN	YES	NO
Itching or burning	❑	❑
Sores or rashes	❑	❑

EARS	YES	NO
Ringing in ears	❑	❑
Left ear	❑	❑
Right ear	❑	❑
Drainage	❑	❑
Left ear	❑	❑
Right ear	❑	❑

NOSE/SINUSES	YES	NO
Drainage	❑	❑
Congestion	❑	❑
Facial pain	❑	❑
Bleeding	❑	❑
Diminished smell	❑	❑
Diminished taste	❑	❑
Sinusitis	❑	❑
Allergy symptoms	❑	❑

RESPIRATORY	YES	NO
Shortness of breath	❑	❑
Cough	❑	❑
Coughing blood	❑	❑
Coughing blood	❑	❑

OFFICE USE ONLY

PATIENT UNABLE TO COMPLETE FORM ______________________

THIS FORM HAS BEEN REVIEWED WITH PATIENT

______________ M.D. ______________ Date
______________ M.D. ______________ Date