Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

ROCKY MOUNTAIN ENT ASSOCIATES

1400 S. Potomac St., Ste.240, Aurora, CO 80012
Phone (303) 750-8600 | Fax (303) 743-7800

14100 E Arapahoe Rd, Ste. 250, Centennial, CO 80112
Phone (720) 979-0855 | Fax (303) 400-8311

Pediatric Patient Intake Form

Name: _____DOB: _____ Age: _____

Parents/Guardians Name(s):_____

Who referred you to us?
Referring Physician: _____

Please list the names of the patient's current medical providers:

Primary Care Provider Name: _____

Phone: _____

Other Provider: _____

Phone: _____ Specialty: _____

Other Provider: _____

Phone: _____ Specialty: _____

What is the preferred pharmacy for the patient?

Name: _____Location: _____

City: _____ Phone#: _____

What is the reason for the patient's visit today?

_____

_____

How long has the patient had symptoms? _____

What makes things better? _____

What makes them worse? _____

What treatments have been tried?

_____

_____

What tests have been done? _____

_____

Has allergy testing been done? _____

Name: _____DOB: _____

Medical History

Any additional information, please continue on the back of the page

Please list any prescribed, over-the-counter, or herbal medicines, including doses and number of times per day patient is currently taken.

☐ **Patient is currently NOT taking any Medications.**

#	Name	Strength	Take	Frequency	Start Date	End Date
1.						
2.						
3.						
4.						
5.						

Has the patient had any of the following health problems? Please check all that apply

☐ **None listed below.**

☐ Heart Attack	☐ Tuberculosis	☐ Back problems	☐ Kidney infections	☐ Arthritis/ Joint Pain
☐ Heart Disease	☐ Pneumonia	☐ Diabetes	☐ AIDS/HIV+	☐ Cystic Fibrosis
☐ Heart Murmur	☐ Stroke	☐ Hypoglycemia	☐ Thyroid problems	☐ Down's syndrome
☐ Chest Pain	☐ Seizures	☐ Hepatitis	☐ Sinus Disease	☐ Cancer, Type:
☐ High Blood Pressure	☐ Head Injury	☐ Jaundice	☐ Hearing Loss	_____
☐ Asthma	☐ Migraines	☐ Bleed Disorder	☐ Reflux Disease	
☐ Emphysema	☐ Meningitis	☐ Anemia	☐ Ulcers	

#	Other conditions:	Date of Diagnosis
1.		
2.		
3.		

Patient's Hobbies/activities: _____

Patient exposed to smoking? Yes☐ No☐

Who lives in the patient's home? _____

Patient in school/Daycare? ☐ Yes ☐ No Grade? _____

Please list any allergies to medications:

☐ **No known allergies.**

#	Agent/Substance	Reaction
1.		
2.		

Please list any previous surgeries and dates

☐ **No previous surgeries.**

#	Date (Mo/Year)	Surgery
1.		
2.		
3.		

Name: _____DOB: _____

Please check if any of the patient's blood relatives have a history of any of the following:

☐ **None listed below.**

Family Member	Alive/ Deceased	Diabetes	High Blood Pressure	Breast Cancer	Heart Disease	Lung Cancer	Colon Cancer	Heart Attack	High Cholesterol	Asthma	Hearing Loss
Father											
Mother											
Daughter(s)											
Son(s)											
Sister(s)											
Brother(s)											
Spouse/Life Partner											
Paternal Grand Father											
Paternal Grand Mother											
Maternal Grand Father											
Maternal Grand Mother											

Other significant family history: _____

_____

Any of the following symptoms in the last month? **Indicate if "No Problems" in each category**

☐ General: No Problems	☐ Nose: No problems	☐ Cardiovascular: No Problems	☐ Neuro/Psych: No problems	☐ Skin: No problems
☐ Fever	☐ Obstruction/congestion	☐ Chest pain	☐ Numbness	☐ Skin lesions/rashes
☐ Weight Loss	☐ Postnasal drip	☐ Shortness of breath	☐ Weakness	☐ Pigmentation changes
☐ Weight gain	☐ Drainage/pus	☐ Swollen legs/ ankles	☐ Tingling	☐ Allergy: No problems
☐ Night sweats	☐ Loss of smell	☐ Dizziness or fainting	☐ Convulsions	☐ Inhalant allergy
☐ Loss of appetite	☐ Throat: No problems	☐ Palpitations	☐ Blackouts	☐ Contact allergy
☐ Eyes: No Problems	☐ Recent voice change	☐ Gastro: No problems	☐ Sensory disturbances	☐ Environmental allergies
☐ Blurry vision	☐ Difficulty breathing	☐ Nausea/vomiting	☐ Motor disturbances	☐ Food allergy
☐ Double Vision	☐ Difficulty swallowing	☐ Vomiting blood	☐ Depression	☐ Latex allergy
☐ Change in vision	☐ Can't clear throat	☐ Heartburn	☐ Memory difficulties	☐ Hematology:No problems
☐ Eye pain	☐ Chronic cough	☐ Abdominal pain	☐ Endocrine: No problems	☐ Anemia
☐ Excess tearing	☐ Hoarseness	☐ Constipation	☐ Increased appetite	☐ Bleeding tendency
☐ Ears: No Problems	☐ Sore throat	☐ Blood in stool	☐ Heat intolerance	☐ Prior transfusion
☐ Hearing loss	☐ Loss of taste	☐ Diarrhea	☐ Cold intolerance	
☐ Ringing in ears	☐ Pulmonary: No problems	☐ Genitourinary: No Problems	☐ Increased water intake	
☐ Ear pain	☐ Wheezing	☐ Painful urination	☐ Muscle/Joint: No Problems	
☐ Ear drainage	☐ Coughing	☐ Frequent urination	☐ Joint pain/limited motion	
☐ Ear fullness	☐ Coughing up blood	☐ Blood in urine	☐ Muscle weakness	
☐ Dizziness	☐ Pain with breathing		☐ Back pain	

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

ROCKY MOUNTAIN ENT ASSOCIATES
FINANCIAL POLICY

We would like to thank you for choosing Rocky Mountain ENT Associates for your care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE

You are here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures**. *If you see one of our audiologists in addition to the physician, there is a separate charge for their service.** Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, radiology)

MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your appointment two business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

CHECK IN

We respect and value your time. ***If you are more than 10 minutes late for your appointment, we may need to reschedule***. We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient fashion while receiving the highest quality care.
ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 10 minutes prior** to their appointment for check in.
NEW PATIENTS: If it is your first time to our office, please arrive 15 minutes prior to your appointment time with your **paper work completed**. If the paper work is not complete, please arrive **30 minutes** prior to the appointment time.

PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service*. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered, **deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due with-in 30 days.
***We do not collect co-pays at the time of service for our audiology services. If your plan applies a co-pay for these services, we will send a statement to you.** *Most Aetna and Cigna plans apply co-pays to both the office visit and to the audiology service.*

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance.

INSURANCE

All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility to provide accurate and timely insurance information.

INSURANCE REFERRALS:

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

Guardian/Responsible Party Signature: _____ Date: _____

Diagnostic Nasal Endoscopy Financial Notice

Payment of Procedure: Your insurance company considers Diagnostic Nasal Endoscopy with or without Removal of Polyps/Debridement, Nasopharyngoscopy, Rigid or Flexible a surgical procedure. These procedures are not covered by your office co-payment and may be subject to your deductible and additional co-insurance. If your surgical deductible has not been met, the allowable charge per your contract with your insurance company will be applied to the patient's responsibility. The charge may be anywhere from $0 - $3000.00. The amount your insurance covers depends on your individual contract. **This is not included in your post-operative care.**

The procedure codes used are as follows:

CPT **92511** Nasopharyngoscopy, Rigid
CPT **31575** Nasopharyngoscopy, Flexible
CPT **31231** Nasal Endoscopy, Diagnostic
CPT **31237** Nasal Endoscopy with Removal of Polyps/Debridement