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
7180 E. Orchard Rd Suite 202 Greenwoood Village, CO 80111
Phone (303)783.2670 Fax (303)290-6317

Dear

Thank you for choosing Rocky Mountain ENT Associates for your care. We have 4 physicians, 4 audiologists and three practice locations. We ask you to complete your paperwork ahead of time. The paperwork takes approximately 20 minutes to complete. If you are an established patient and have completed our paperwork in the past we may ask you to update it if it has been over one year. Below are some quick FAQs for you to help make your visit the best experience it can be:

*°Arrive 10 minutes early with your completed paperwork*

*°Bring a photo ID and your Insurance Card*

*°Make sure your insurance company does not require a referral to be processed through your insurance company prior to your visit*

*°If your Insurance is Medicaid make sure it is not Denver Health, University or Kaiser as we do not accept those plans.*

*°If your insurance has a co-pay we will collect the co-pay at the time of visit.*

*°If your insurance has co-insurance we will collect $20.00 that will be applied to your co-insurance*

*°If you see a physician and an audiologist on the same day it is possible your insurance will charge you two co-pays. We will only collect one at the time of service.*

After your visit you will receive an email asking you to complete a survey. The survey takes about 3 minutes. It is important to us to hear how we did. If your experience was not excellent please call Christy, our Practice Manager at 720-475-8714 or ask for her before you leave so we can make sure your visit meets your expectations.

We have a web portal for your convenience. You will receive the credentials at check in. If you do not, please ask. The web portal allows you to access your medical records any time. In order for you to access the portal we do need your social security number as it is a unique identifier.

If you need to cancel your appointment, please do so as soon as possible. We look forward to seeing you soon.

Your appointment is at the following location:_____________________and on __________ at ________

Sincerely,

Rocky Mountain ENT Associates

1400 S. Potomac St. Suite 240 • Aurora, CO 80012
14100 E. Arapahoe Road • Centennial, CO 80112
Phone 303.750.8600 • Fax 303.743.7800

# Pediatric Patient Intake Form

**Date:**__________ **Name:** ______________________ **DOB:** ______________ **Age:** __________

***Parent/Guardians Name(s):*** ______________________________

***Who referred you to us? (Referring Physician):*** ______________________________

***Please list the names of current medical providers:***

Primary Care Provider: ______________________ Phone: ______________

Other Provider: ______________________ Phone: ______________

***What is your preferred pharmacy?***

Name/Location: ______________________ Phone: ______________

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

______________________________________________________________

______________________________________________________________

***How long have the symptoms been present?*** ______________________________

***What makes them better?*** ______________________________

***What makes them worse?*** ______________________________

***What treatment(s) have been tried?*** ______________________________

______________________________________________________________

***What tests have been done?*** ______________________________

***Has allergy testing been done?*** __________ ***If yes, when?*** ______________

## MEDICAL HISTORY

***Please list your prescribed, over-the-counter, or herbal medicines. Include doses and number of times taken per day:***

☐ **I am currently not taking medications**

| Name | Strength | # Taken | How Often | Start Date | End Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

***Please List Any Allergies:***

☐ **No known allergies**

| Agent/Substance | Reaction | Agent/Substance | Reaction |
|---|---|---|---|
| | | | |
| | | | |

**Date:__________ Name:______________________________ DOB:________________ Age:__________**

## *Has the patient had any of the following health problems? Check all that apply*

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

☐ **None of these listed**

| Other Conditions: | Date Diagnosed | Other Conditions: | Date Diagnosed |
|---|---|---|---|
| | | | |
| | | | |

## *Please List Prior Surgeries:* ☐ No surgeries

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| | | ☐ ☐ | |
| | | | |

Patient's Hobbies/Activities: ______________________________ Is the patient exposed to smoking? ☐ Yes ☐ No

Who lives in the patient's home? ________________ Is the patient in daycare/school? ☐ Yes ☐ No What grade? ______

## *Please check if any blood relatives have any of the following:*

| 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) | | | | | | | | | | | |
| Paternal Grand Father | | | | | | | | | | | |
| Paternal Grand Mother | | | | | | | | | | | |
| Maternal Grand Father | | | | | | | | | | | |
| Maternal Grand Mother | | | | | | | | | | | |

## *Please check if you have had and of the following in the last month:*

| | General: No Problems | | Nose: No problems | | Heart :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 | | |

# 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***_________________

# 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.*

**SCOPE FINANCIAL FORM**

________***I have read the*** Diagnostic Nasal Endoscopy Financial Notice ***and agree to pay my patient balance if this surgical procedure is applied to my deductible or co-insurance.***

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: