SINUS RELIEF CENTER

(PLEASE PRINT CLEAR AND COMPLETE ALL FIELDS APPLICABLE)

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Preferred Pronoun(s): _____

Gender: ☐ MALE ☐ FEMALE ☐ PREFER NOT TO ANSWER

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Social Security #: _____ Email: _____

Employer: _____ Employer Phone: _____ Position: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referred by: ☐ Physician: _____ ☐ Friend: _____

☐ Facebook ☐ Instagram ☐ TV Ad ☐ Google ☐ YouTube ☐ Valpak ☐ Yelp

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Name: _____ Member ID #: _____ Group #_____

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Member ID #: _____ Group #_____

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENTS

PLEASE READ AND INITIAL BELOW

_____I hereby authorize medical treatment by the providers at Sinus Relief Center.

_____I fully acknowledge that all office visits will be paid in full at the time of visit, unless otherwise contracted by my insurance. I understand that all co-payments and deductibles are due at the time of service. I understand that my insurance policy is a contract between my insurance company and myself. I further understand that I am responsible for any fees not covered by my insurance.

_____I understand that I will be charged $25 for an unexcused no-show or cancellation within 24 hours of my appointment time.

_____I understand that if FMLA or Disability forms are required to be completed for my condition, I am aware that there will be a fee of $35.

_____In the event of default on any payments due to Dr. Vincent Nalbone, MD/Sinus Relief Center, I agree to pay the full costs of collection, including attorney fees. I hereby authorize the filing of any insurance in force and the direct payment to Dr. Vincent Nalbone, MD/Sinus Relief Center of any amounts due on my claim.

_____I authorize Sinus Relief Center to release all pertinent medical records necessary to facilitate insurance billing or medical care; and authorize the creditor or higher agent to make any insurance verification and release of all information needed to process claims. I hereby authorize Sinus Relief Center to receive, mail, fax, or email my medical records to another physician or medical facility during my diagnosis and treatments.

_____I hereby authorize the providers of Sinus Relief Center to conduct Telemedicine video calls, if necessary.

_____I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document attached. I understand that I can request a copy of the Notice of Privacy Practices (HIPAA).

I hereby authorize the medical staff of Sinus Relief Center to discuss my medical care in detail with *(LIST NAMES):*

_____

_____

Patient Name: _____ **Height:** _____ **Weight:** _____

MEDICAL HISTORY

Please list any medications you are currently taking below (include vitamins & supplements):

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you allergic to any medications? ☐ **No** ☐ **Yes, List:** _____

Reaction to medications: _____

Have you ever had surgery? ☐ **No** ☐ **Yes, List:** _____

Hospitalizations? ☐ **No** ☐ **Yes, List:** _____

Any medical problems that run in the family? ☐ **No** ☐ **Yes, List:** _____

Are you taking birth control? ☐ **No** ☐ **Yes** **Are you pregnant?** ☐ **No** ☐ **Yes** ☐ **I don't know?**

Pharmacy Name: _____ **Pharmacy Address:** _____

Primary Care Physician Name: _____ **Phone:** _____

(Please circle if you have had or currently have any of the following problems)

Constitutional: fevers / sweats / weight loss / change in appetite
Eyes: new vision problems / double vision / cataracts
ENT: ear / nose / throat
Hematologic/ Lymphatic: bleeding disorders / easy bruising
Cardiovascular: murmur / heart disease / heart attack / chest pain
Respiratory: cough, asthma / tuberculosis / shortness of breath / wheezing
Gastrointestinal: nausea / vomiting / diarrhea / abdominal pain / acid reflux / indigestion
Genitourinary: infections / difficulty urinating / frequent urination
Psychiatric: ADHD /anxiety / depression / drug dependence
Endocrine: diabetes / thyroid problems
Allergic/ Immunologic: immune problems / food allergy / environmental allergy / eczema / HIV
Skin Problems: skin infection / rashes / skin changes / skin cancer
Musculoskeletal: arthritis / joint pain / mobility problems
Neurological: seizures / headaches / vertigo / weakness / stroke / developmental delay

PERSONAL HISTORY

Are you Claustrophobic? ☐ **Yes** ☐ **No**

Do you Smoke or chew tobacco? ☐ **Yes** ☐ **No** **Drink alcohol?** ☐ **Yes** ☐ **No** **Use other drugs?** ☐ **Yes** ☐ **No**

Do you have metal in the body? ☐ **Yes** ☐ **No**

Lives in: ☐ **House** ☐ **Apartment** ☐ **Condo** ☐ **Other:** _____

Are you? ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other:** _____

Have you traveled out of the country recently? ☐ **Yes** ☐ **No**

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____

CONSENT TO RECEIVE APPOINTMENT REMINDERS

By signing below, I authorize Sinus Relief Center/Vegas ENT/Vincent Nalbone, MD, to send appointment reminders through my email address, SMS mobile text, and voice messaging calls through our third-party company Updox.

_____ **(*Patient initials*)** I consent to emails to receive communications as stated above.

The **email** that I authorize to receive email messages for appointment reminders is:

_____

_____ **(*Patient initials*)** I consent to receive text messages to receive communications as stated above.

The **mobile number** that I authorize to receive text messages for appointment reminders is:

(_____) _____ - _____

_____ **(*Patient initials*)** I consent to receive voice messaging calls to receive communications as stated above.

The **phone number** that I authorize to receive voice messaging calls for appointment reminders is:

(_____) _____ - _____

CHECK PREFERRED METHOD TO RECEIVE APPOINTMENT REMINDERS

☐ Email Reminders ☐ Text Messaging Reminders ☐ Voice Messaging Calls

I understand that this request to receive emails, text messages and/or voice messaging calls will apply to all future appointment reminders unless I request a change in writing.

_____ _____

PATIENT NAME **DATE OF BIRTH**

_____ _____

PATIENT SIGNATURE **DATE**

SINUS RELIEF CENTER

Date: _____

Patient Name: _____ Date of Birth: _____

PLEASE CHECK ALL MEDICATIONS YOU HAVE USED

ANTIBIOTICS

☐ Penicillin ☐ Amoxicillin ☐ Augmentin ☐ Zpack

☐ Omnicef (Cefdinir) ☐ Bactrim ☐ Doxycycline ☐ Clindamycin

☐ Cipro ☐ Levaquin ☐ Biaxin ☐ Cefdinir

☐ Other: _____

ANTIHISTAMINES

☐ Claritin (Loratidine) ☐ Allegra (Fexofenadine) ☐ Zyrtec (Cetirizine)

☐ Benadryl ☐ Clemastine (Tavist) ☐ Chlorpheniriamine (Chlor-Trimeton)

☐ Clarinex ☐ Seldane ☐ Brompheniriamine (Dimetane)

☐ Seldane ☐ Xyzal ☐ Other: _____

NASAL SPRAYS

☐ Flonase ☐ (Fluticasone) ☐ Nasacort ☐ Rhinocort

☐ Dymista ☐ Budesonide ☐ Veramyst ☐ Nasonex

☐ Astelin ☐ Beconase ☐ Vancenase ☐ Atrovent

☐ Azelastine ☐ Qnasal ☐ Nasarel ☐ Zetonna

☐ Nasalide ☐ Tri-Nasal ☐ Omnaris ☐ Other: _____

RINSES

☐ Saline spray ☐ Neti Pot ☐ Neil-Med Spray ☐ Ocean Spray

☐ Navage ☐ Water-Pik ☐ Other: _____

DECONGESTANTS

☐ Sudafed ☐ Afrin ☐ Neosynephrine ☐ 4-Way nasal spray

☐ Other: _____

OTHER

☐ Steroids ☐ Mucinex ☐ Robitussin ☐ Other: _____

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SINUS RELIEF CENTER

Sino-Nasal Outcome Test (SNOT-22)

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Today's Date: _____

Patient Name: _____ **DOB:** _____

** Consider how severe your sinus symptoms are when you experience them and how often it occurs. Rate each item below on how "bad" it is by circling the number that corresponds with how you are feeling using this scale. ** On the far-right column, mark the most important symptoms that are currently affecting you (maximum of 5 symptoms).	NO PROBLEM	VERY MILD PROBLEM	MILD OR SLIGHT PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	AS WORSE AS IT CAN BE	TOTAL	*MOST IMPORTANT PROBLEM*
NEED TO BLOW NOSE	0	1	2	3	4	5		O
NASAL BLOCKAGE/CONGESTION	0	1	2	3	4	5		O
SNEEZING/ALLERGIES	0	1	2	3	4	5		O
RUNNY NOSE	0	1	2	3	4	5		O
COUGH	0	1	2	3	4	5		O
POST-NASAL DRIP, CONSTANTLY CLEARING THROAT	0	1	2	3	4	5		O
THICK NASAL DISCHARGE	0	1	2	3	4	5		O
EAR FULLNESS	0	1	2	3	4	5		O
DIZZINESS	0	1	2	3	4	5		O
EAR PAIN	0	1	2	3	4	5		O
FACIAL PAIN/PRESSURE	0	1	2	3	4	5		O
DECREASED SENSE OF SMELL/TASTE	0	1	2	3	4	5		O
DIFFICULTY FALLING ASLEEP	0	1	2	3	4	5		O
WAKE UP AT NIGHT COUGHING/CHOKING	0	1	2	3	4	5		O
LACK OF A GOOD NIGHT SLEEP	0	1	2	3	4	5		O
WAKE UP TIRED	0	1	2	3	4	5		O
FATIGUE	0	1	2	3	4	5		O
REDUCED PRODUCTIVITY	0	1	2	3	4	5		O
REDUCED CONCENTRATION	0	1	2	3	4	5		O
FRUSTRATED/RESTLESS/IRRITABLE	0	1	2	3	4	5		O
SAD	0	1	2	3	4	5		O
EMBARRASSED	0	1	2	3	4	5		O

TOTAL	

Have you had allergy testing done before? O Yes O No

If YES, what were the results? _____

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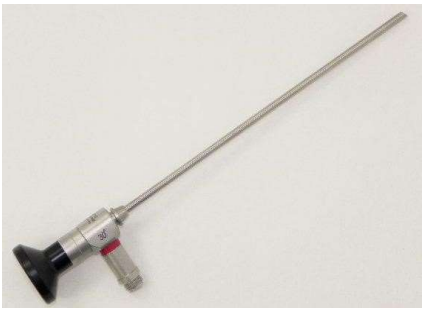
Disclosure for Nasal Endoscopy

Nasal endoscopy is a procedure to look into the nasal and sinus passages. It is performed using an endoscope. The endoscope is a scope that has a light. The scope does not need to be put all the way into the nose to see all parts of the nose. This exam is better than a regular nasal exam and does not hurt. Your practitioner will perform this procedure in our office. A nasal endoscopy is a better exam because it can detect polyps or other things deeper in the nose that may have been missed with a regular exam. This can make a difference in your treatment plan.



Please initial below:

_____ I authorize my practitioner to perform a nasal endoscopy on me for the purpose of identifying any or all possible conditions that I may have.

_____ I understand that a nasal endoscopy is usually very safe and causes no harm. For twenty years, we have never seen a patient go to the emergency room or hospital from having a nasal endoscopy.

_____ I understand that most insurances cover this type of procedure. I further understand that my insurance may have an additional co-pay or deductible for the nasal endoscopy procedure.

_____ I understand that insurances categorize a nasal endoscopy as a surgical procedure, but this is not a surgery and no surgery will be performed, just the scope looking into my nose. I further understand that when I see my EOB for the nasal endoscopy, it will be categorized as “surgery".

_____ I certify that I have read and understand the entirety of the contents in this form. I also understand the benefits and risks involved above and wish to proceed with the nasal endoscopy procedure. I further understand that I may obtain a copy of this informed consent at my request.

Patient Name (Print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____ **Time:** _____

Witness Signature: _____ **Date:** _____ **Time:** _____

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