North Shore Ear, Nose and Throat, P.C.

Adult and Pediatric Otolaryngology

(PLEASE PRINT)

PATIENT PROFILE

DATE _____ NAME_____DATE OF BIRTH: _____

ADDRESS:_____

CITY, STATE, ZIP: _____

TELEPHONE: ( ) _____CELL #: ( ) _____EMAIL:_____

PATIENT'S SS #: _____AGE: _____ SEX: _____ MARITAL STATUS: M / S / W / DIV / SEP

EMPLOYER: _____ EMPLOYER ADDRESS: _____

EMPLOYER PHONE NUMBER: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____TELEPHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: NAME: _____POLICY #: _____

GROUP #: _____ CO-PAY: _____

POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SELF: ____ SPSE: ____ CHILD: ____ OTHER: _____

SECONDARY INSURANCE: NAME: _____POLICY #: _____

GROUP #: _____ CO-PAY: _____

POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SELF: ____ SPSE: ____ CHILD: ____ OTHER: _____

PRIMARY CARE DOCTOR OR REFERRING DOCTOR: _____

ADDRESS: _____

CITY STATE, ZIP: _____

TELEPHONE #: _____ FAX #: _____

PHARMACY:_____ PHONE #:_____

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NAME: _____**DATE:** _____

DESCRIBE REASON FOR TODAY'S VISIT (EX. EAR PAIN, SORE THROAT, ETC):___

_____

MEDICAL CONDITIONS (EX. HIGH BLOOD PRESSURE, DIABETES, GOUT, ETC):

1_____ **2**_____ **3**_____

4_____ **5**_____ **6**_____

_____

CURRENT MEDICATIONS (PLEASE SPECIFY ABOVE WHAT YOU ARE TAKING EACH MEDICATION FOR):

1_____ **2**_____ **3**_____

4_____ **5**_____ **6**_____

7_____ **8**_____ **9**_____

_____

SURGICAL HISTORY (EX. HERNIA REPAIR, KNEE REPLACEMENT, ETC):

1_____ **2**_____ **3**_____

4_____ **5**_____ **6**_____

_____

ALLERGIES TO MEDICATION/S:

1_____ **2**_____ **3**_____

_____

TOBACCO USE (CIRCLE ONE): NEVER/OCCASIONAL/ DAILY /FORMER

ALCOHOL USE (CIRCLE ONE): NEVER/ SOCIAL/ DAILY / HEAVY DRINKING

FAMILY HISTORY OF MEDICAL CONDITIONS:_____

_____

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.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing and providing treatment.

Your health information may be used in the course of day-to-day activities in providing health care by North Shore Ear, Nose and Throat, P.C. (NSENT), disclosed to third-party co-payers for the strict purpose of your billing claims submissions and for conveying supporting information to third party co-payers in the process of preauthorization for procedures.

Your health information may be disclosed to law enforcement agencies and or public health agencies, to support government audits & inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting (such as public health reporting of communicable diseases).

Use or disclosure of your health information for any other purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

In addition, your health information may be used by our staff to send you appointment reminders, and/ or information on the treatment and management of your medical condition.

You have certain rights under the federal privacy standards. These include: 1) The right to request restrictions on the use and disclosure of your protected health information. 2) The right to receive confidential communications concerning your medical condition. 3) The right to inspect and copy your protected health information. 4) The right to amend or submit corrections to your protected health information. 5) The right to receive an accounting of how and to whom your protected health information has been disclosed. 6) The right to receive a printed copy of this notice.

NSENT is required by law to maintain the privacy of your information and to provide you with this notice. We reserve the right to amend or modify our privacy policies and practices as permitted by law. Any changes may be mandated by changes in federal law. If any changes occur, we will provide you with a revised notice upon your next visit. The revised notice will apply to all protected health information that we maintain. You may generally inspect or copy the protected health information we maintain. As permitted by federal regulations, we require that all requests to inspect or copy protected health information be submitted in writing.

If you have any comments or complaints about our privacy practices, or if you feel like your privacy rights have been violated, please contact us in writing, or address the issue with our physicians or staff. Our address is: 2001 Marcus Ave suite S-10, New Hyde Park, NY 11042 and our phone number is 516-627-7100.

This notice is effective May 10, 2011.

North Shore Ear, Nose and Throat, P.C.

2001 Marcus Ave. Suite S-10
New Hyde Park, N.Y. 11042
Tel 516.627.7100 Fax 516.627.7105

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I, _____, have read a copy of the **North Shore Ear,**
Patient Name

Nose and Throat, P.C. *Notice of Privacy Practices* form.

_____
Signature of Patient

_____
Date

I hereby authorize you to notify/discuss my medical condition with the following:

Primary Physician _____

Family Member _____

Family Member _____

Other _____