Drake & Presti ENT Surgical Associat

213 Su...nit Rd., Mountainside, NJ 07092 P: 908-233-2111 F: ...8-458-9944

PLEASE FILL OUT COMPLETELY AND BRING WITH YOU TO YOUR APPOINTMENT

PATIENT INFORMATION:

Patient Name: ______________ DOB: ______ Age: ______

Address: ______________ City: ______ State: ______ Zip: ______

Home P#: ______ Cell#: ______ Work#: ______ Sex: M F

Marital Status: Married: ______ Single: ______ Divorced: ______ Widowed: ______ Partner: ______

Email: ______________ Social Security #: ______

REFERRAL SOURCE:

Primary Care Physician: ______ Town: ______ Phone: ______

Referred By (if different from PCP): ______ Phone: ______

Emergency Contact/Relationship to Patient: ______ Phone: ______

Pharmacy: ______ Town: ______ Phone: ______

INSURANCE INFORMATION: (THIS AREA MUST BE FILLED IN AND CARDS SHOWN WITH PHOTO ID)

Primary Insurance: ______ Policy ID#: ______ Group #: ______

Name of Policy Holder: ______ Relationship of Patient to Policy Holder: ______

Policy Holder's SS#: ______ DOB: ______ Employer: ______

Insurance Company Address: ______

Secondary Insurance: ______ Policy ID#: ______ Group #: ______

Name of Policy Holder: ______ Relationship of Patient to Policy Holder: ______

Policy Holder's SS#: ______ DOB: ______ Employer: ______

Insurance Company Address: ______

Tertiary Insurance: ______ Policy ID#: ______ Group #: ______

Name of Policy Holder: ______ Relationship of Patient to Policy Holder: ______

Policy Holder's SS#: ______ DOB: ______ Employer: ______

Insurance Company Address: ______

Prescription Coverage Provided By: ______ ID#: ______

Signature Required Below:

Private Insurance Authorization for Assignment of Benefits/Information Release/Appeals

I, the undersigned, authorize **Drake & Presti ENT Surgical Associates** to release to my insurance company, or their agent, information concerning healthcare, advise, treatment or supplies provided to me. I also authorize payment of medical benefits to Drake & Presti ENT Surgical Associates to for any services furnished me by the practice. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize Drake & Presti ENT Surgical Associates to appeal any claim denials/additional payment on my behalf.

Signature: ______________ Date: ______

(Parent or Guardian if Patient is under 18)

Medicare Lifetime Signature on File

I request tha payment of authorized Medicare benefits be made to **Drake & Presti ENT Surgical Associates** to for any services rendered by the physician. I authorize any holder of medical information about myself to be released to the Healthcare Administration and its agents to determine these benefits payable for related services. practice. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that I am financially responsible for any amount not

Signature: ______________ Date: ______

Drake & Presti ENT Surgical Associates
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.**

Patient's Last Name ____________________ **First** ____________________ **MI** ________

Sex ☐ Male ☐ Female **Race:** ____________________ **Height:** ________ **Weight:** ______

Preferred Method of Contact: **Email:** __________ **Home:** __________ **Work:** __________ **Cell:** __________

Pharmacy Name: ____________________ **Pharmacy #:** ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Preferred Language:** ______________

If Applicable:

Have you had an influenza vaccine within the last year: { } yes { } no
If yes: Month/Year ____________________ **Type if known**: ____________________

Have you had a colonoscopy within the last 10 years: { } yes { } no
If yes: Month/Year ____________________

Have you had a Breast Cancer Screening within the last 10 years: { } yes { } no
If yes: Month/Year ____________________

Have you had a Cervical Cancer Screening within the last 10 years: { } yes { } no
If yes: Month/Year ____________________

Are you interested in having a consultation for non-invasive facial rejuvenation: { } yes { } no

REASON FOR TODAY'S VISIT: ____________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ **Yes** ____ **No.** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS.

Please list ALL previous surgeries from childhood to present including cosmetic procedures & diagnostic testing under anesthesia:

TYPE OF PROCEDURE/FOR WHAT CONDITION	DATE	AGE

X ____________________ ____________ ____________

Patient Signature **Today's Date** **Entered By (Office use only)**

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct treatment and follow ups among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I understand your Notice of Privacy Practices and I am able to ask for a copy containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at address above to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide to such restrictions.

Patient Name: ______________________________________

Signature: ___________________________Date:___________

Billing Notice

I understand that I am financially responsible for services not covered by my insurance company, including any deductible, co pays or coinsurance. I am also aware that depending on the nature of my specific medical condition and treatment, my physician may perform an in-office procedure (e.g. nasal endoscopy/laryngoscope) that are not included in the standard office visit. This is because, as a highly trained specialist, my physician wants to ensure that all appropriate steps are taken to provide me with the absolute best medical care possible.

These procedures will be billed separately from your visit charges. Depending on your individual insurance policy and carrier, these procedures may be classified as “surgery” and applied to an in-network deductible. Please be assured that Drake and Presti ENT Surgical Associates always follow strict billing and coding guidelines and all procedures are performed in the best interest of you, our valued patient.

Patient Name: ______________________________________

Signature: ___________________________Date:___________

Dr. William Drake III Dr. Paul M. Presti

Drake & Presti ENT Surgical Associates
213 Summit Rd., Mountainside, NJ 07092
P: 908-233-2111 F: 908-458-9944

Notice of Privacy Practices Available Upon Request

PERMISSION OF PATIENT CONTACT: (Effective 4/14/08 under Federal Law)

Patient Name: ______________________ D.O.B. ______________ Date: ______________

Signature: ______________________ Relationship (If not patient): ______________________

Contact Information: In the event that ***Drake & Presti ENT Surgical Associates*** staff and/or physicians are unable to contact you at with the phone numbers provided and would like to provide you with information regarding laboratory results, appointment reminder, billing statements, etc., the details of such information will not be left on your answering machine or voicemail. Our message to you may simply be a request for a return call to address such specific matters.

If ***Drake & Presti ENT Surgical Associates*** staff and/or physicians need to contact you with laboratory results, appointment reminder, billing statements, etc., please provide us with the necessary contact information that is best to reach you during the day.

Primary phone: ______________________ Leave message on voicemail? Y N

Secondary phone: ______________________ Leave message on voicemail? Y N

Tertiary: ______________________ Leave message on voicemail? Y N

If you have provided our office with a work number and you are unavailable, may we leave a message with a receptionist or secretary requesting a call back to our office from you? Y N

Please list the names of any person or persons that may be involved in your healthcare that we may be permitted to discuss anything concerning your medical status. This person (i.e. spouse, partner, parent, child, etc.) may also be elected by you to answer questions on your behalf. Please note, if a name is not listed, we are required by law to protect your information and we will not discuss anything pertaining to your healthcare with that unlisted person.

Name: ______________________ Relationship to patient: ______________

Name: ______________________ Relationship to patient: ______________

Name: ______________________ Relationship to patient: ______________

Name: ______________________ Relationship to patient: ______________

213 Summit Road Suite 1
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908-233-2111
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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Drake and Presti ENT Surgical Associates. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- **Effective January 1, 2023, any established patient who fails to show and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50.00 fee.**
- **Any established patient who fails to show for their appointment without 24 hours' notice a second time will be charged a $100 fee.**
- **Any new patient who fails to show for their initial visit will not be rescheduled without a credit card on file. If the patient does not show for a second time a $100.00 no show fee will be charged to the credit card on file and no future appointments will be rescheduled.**
- The fee is charged to the patient, not the insurance company, and is due prior to the patient's next office visit.
- As a courtesy, we make reminder calls for appointments.
- We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

____

Signature Patient/Guardian | Date