SINUS RELIEF CENTER

(PLEASE PRINT CLEAR AND COMPLETE ALL FIELDS)

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: Male / Female

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: _____

☐Social Media: _____ ☐ Billboard ☐ Google ☐ YouTube ☐Other: _____

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 and 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 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 co-payments and deductibles are due at the time of service. I understand that I will be charged $25 for an unexcused no-show or cancellation within 24 hours of my appointment time. If FMLA or Disability paperwork is required for my condition, I am aware there will be a fee of $35. I hereby acknowledge that I am able to request a copy of the Notice of Privacy Practices (HIPAA).

_____I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document attached. I understand that I am able to request a copy of the HIPAA Notice of Privacy Practices.

_____In the event of default on any payments due to Dr. Vincent Nalbone, MD, 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 of any amounts due on my claim. I further authorize the office of Dr. Vincent Nalbone, MD to release any and all pertinent medical records necessary to facilitate insurance billing or medical care; and authorize the creditor or higher agent to make any employment or insurance verification and release of all information needed to process claims. I hereby authorize the office of Dr. Vincent Nalbone, MD to receive, mail, fax, or e-mail my medical records to another physician or medical facility in the course of my diagnosis and treatments.

I hereby authorize Dr. Vincent Nalbone, MD to discuss my medical care in detail with (List names):

_____

MEDICAL HISTORY

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

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 medications? List: _____

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

PERSONAL HISTORY

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

Hospitalizations? ☐ No ☐ Yes, List: _____

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

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

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

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

Are you Claustrophobic? ☐ Yes ☐ No Do you have any metal in the body? ☐ Yes ☐ No

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

(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 Problem: skin infection / rashes / skin changes / skin cancer
Musculoskeletal: arthritis / joint pain / mobility problems
Neurological: seizures / headaches / vertigo / weakness / stroke / developmental delay

Patient / Guardian / Parent Printed Name: _____

Patient/ Guardian/ Parent Signature: _____ Date: _____

Vincent Nalbone, M.D.

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