ENT NEW YORK Vandana Kumra, MD, FACS

PATIENT INFORMATION

LAST NAME: ____________ FIRST NAME: ____________ DOB: ____________ SEX: ________

ADDRESS INCLUDE ZIP: ____________

HOME PHONE: ____________ CELL PHONE: ____________ WORK PHONE: ____________

EMAIL: ____________ SOCIAL SECURITY #: ____________ PRIMARY LANGUAGE: ____________

NAME OF EMPLOYER/SCHOOL: ____________ OCCUPATION: ____________

ETHNICITY: ____ HISPANIC/LATINO ____ NON HISPANIC/LATINO ____ **DECLINE TO CHECK**

RACE: ____________ ____ **DECLINE TO ANSWER**

IN CASE OF EMERGENCY CONTACT: ____________ RELATIONSHIP: ____________

PHONE: ____________ ADDRESS: ____________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________

PRIMARY CARE PHYSICIAN: ____________ PHONE: ____________ FAX: ____________

ADDRESS: ____________

PHARMACY INFORMATION

NAME OF PRIMARY PHARMACY: ____________ PHONE: ____________

ADDRESS: ____________ FAX: ____________

NAME OF SECONDARY PHARMACY: ____________ PHONE: ____________

ADDRESS: ____________ FAX: ____________

INSURANCE INFORMATION

NAME OF INSURED: ____________ RELATIONSHIP TO PATIENT: ____________ DOB: ____________

ADDRESS: ____________ SOCIAL SECURITY #: ____________

PRIMARY INSURANCE: ____________ ID#: ____________ GROUP#: ____________

SECONDARY INSURANCE: ____________ ID#: ____________ GROUP#: ____________

I verify the accuracy of the above information and I authorize the release of information as provided. By affixing my signature to this document, I understand that if my insurance carrier does not pay within 60 days or if I fail to obtain a valid referral, I am responsible for payment of services.

I hereby authorize Dr. Kumra's insurance company or other health related facility to furnish any and all records, photographs, medical history, services rendered or treatment given to myself or any dependent for the purpose of review or investigation of any claim submitted to the insurer.

PATIENT OR AUTHORIZED SIGNATURE: ____________ DATE: ____________

NAME: ____________ DOB: ____________ AGE: ________ DATE: ____________

ENT NEW YORK

Vandana Kumra, MD, FACS

CHIEF COMPLAINT: ____

VITALS: HEIGHT _____FT. _____IN. WEIGHT: __________LBS. **(STAFF USE- TEMP: _____ RR: _____PULSE:_____BP:____)**

MEDICAL HISTORY: Have you ever had the following (Please check)

☐ CARDIOVASCULAR DISEASE ☐ NEUROLOGICAL DISEASE ☐ BLEEDING DISORDER
☐ KIDNEY DISEASE ☐ CANCER ☐ INFECTIOUS DISEASE (HIV, HEPATITIS)
☐ RESPIRATORY DISEASE ☐ LIVER DISEASE ☐ OTHER: ____________________
☐ **Patient denies any past medical history**

DO YOU HAVE ANY ALLERGIES TO: ☐ MEDICATION ______________________________
☐ FOOD ______________________________
☐ ENVIRONMENTAL INHALANTS______________________________
☐ **Patient denies any allergies**

HAVE YOU EVER BEEN HOSPITALIZED OR HAD ANY SURGERIES? ☐ YES ☐ NO ☐ **Patient denies any surgery**

IF YES FOR WHAT AND WHEN: ____

CURRENT MEDICATIONS	DOSAGE (mg)	HOW OFTEN PER DAY
____________________	______________	________________
____________________	______________	________________
____________________	______________	________________
____________________	______________	________________

☐ **Patient denies taking any medications**

SYMPTOMS: (Please check)

GENERAL: ☐ RECENT WEIGHT GAIN/LOSS ☐ RECENT FEVER
EAR, NOSE & THROAT: ☐ EAR PAIN ☐ RINGING IN EARS ☐ HEARING DIFFICULITY ☐ DIZZINESS ☐ IMBALANCE
☐ NOSE BLEEDS ☐ HEADACHES ☐ NASAL DISCHARGE ☐ NASAL CONGESTION ☐ SORE THROAT
☐ SINUS PRESSURE ☐ DIFFICULITY SWALLOWING ☐ HOARSENESS ☐ OTHER: ____________________
EYES: ☐ BLURRY VISION ☐ GLAUCOMA ☐ ITCHY EYES
RESPIRATORY: ☐ ASTHMA ☐ BRONCHITIS ☐ SHORTNESS OF BREATH
CARDIOVASCULAR: ☐ MURMURS ☐ PACE MAKER ☐ CHEST PAIN
RENAL: ☐ KIDNEY STONES
ENDOCRINE: ☐ THYROID DISEASE ☐ PITUITARY DISEASE
HEMATOLOGIC: ☐ BRUISING/BLEEDING ☐ ANEMIA
NEUROLOGIC: ☐ NUMBNESS ☐ HEADACHES ☐WEAKNESS
PSYCHIATRIC: ☐ DEPRESSION ☐ ANXIETY
MUSCULOSKELETAL: ☐ NECK PAIN ☐ ARTHIRITIS
IMMUNOLOGIC: ☐ ALLERGIES ☐ IMMUNE DEFICIENCY
SKIN: ☐ MOLES ☐ LESIONS ☐ RASHES

FAMILY HISTORY: (Please check)

☐ HEART DISEASE ☐ BLEEDING DISORDERS ☐ DIABETES

☐ HEARING LOSS ☐ CANCER ☐ HIGH BLOOD PRESSURE

☐ **Patient denies any past family history**

SOCIAL HISTORY:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

SMOKING-TOBACCO USE: HAVE YOU EVER SMOKED CIGARETTES? ☐ YES ☐ NO

FOR HOW LONG? ___________________________

DO YOU CURRENTLY SMOKE CIGARETTES? ☐ YES ☐ NO

HOW MUCH? _______________________________

ANY OTHER TOBACCO PRODUCTS? __________________________

ALCOHOL: ☐ NEVER ☐ SOCIAL ☐ LESS THAN 10 DRINKS PER WEEK ☐ MORE THAN 10 DRINKS PER WEEK

PRIVACY PRACTICE

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by the practice of Dr. Vandana Kumra or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your protected health information. The practice of Dr. Vandana Kumra may or may not agree to restrict the use or disclosure of your protected health information. If the practice of Dr. Vandana Kumra agrees to your request, the restriction will be binding on the practice. Use or disclosure of the protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF THE RIGHT TO CHANGE PRIVACY PRACTICES

The practice of Dr. Vandana Kumra reserves the right to modify the privacy practices outlined in the office.

SIGNATURE

I have reviewed this consent form and give my permission to the Practice of Dr. Vandana Kumra to use and disclose my health information in accordance with it.

____

NAME OF PATIENT (PRINT)

____ ________________________

SIGNATURE OF PATIENT DATE

____

SIGNATURE OF PATIENT REPRESENTATIVE

____

RELATIONSHIP OF PATIENT REPRESENTATIVE