NY Center For
Ear Nose Throat, Sinus & Allergy, LLP

KANHAIYALAL KANTU, MD FACS
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SINUS & ALLERGY
HEARING & BALANCE
SNORING & SLEEP APNEA
HEAD & NECK SURGERY

Patient Registration Form

Last Name:_____ **MI:**_____ **Gender:**_____

First Name:_____ **Date of Birth:**_____/_____/_____

SSN:_____-_____-_____ **Marital Status:**_____

Address:_____

Apt/Suite:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Primary Care/Referring Physician:_____ **Phone:**_____-_____-_____

Pharmacy Name:_____ ***Pharmacy Phone*:**_____-_____-_____

***Pharmacy Address*:**_____ **Zip Code:**_____

Contact Information

Home Phone:_____-_____-_____ **Cell Phone:**_____-_____-_____

Work Phone:_____-_____-_____ ***Email:***_____

Emergency Contact Name:_____

Emergency Contact Number:_____-_____-_____

Guarantor (Person To Be Billed If Different Than Patient)

Last Name:_____ **MI:**_____ **Gender:**_____

First Name:_____ **Date of Birth:**_____/_____/_____ **Age:**_____

SSN:_____-_____-_____ **Marital Status:**_____

Address:_____

Apt/Suite:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Patient's or Authorized Person's Signature

I, the undersigned give my authorization to treat and assign directly to NY Center for Ear,Nose, Throat, Sinus & Allergy,LLP all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the treating doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that payment is expected at the time of service.
I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the practice to use and disclose my health information for purposes of treating me,obtaining payment for services rendered to me, and conducting healthcare operations.

Signature:_____ **Date:**_____/_____/_____

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Welcome to Our Practice!

Please circle the item(s) that best describe your reasons for coming in:

- ❑ Nasal congestion
- ❑ Sinus problem
- ❑ Allergies
- ❑ Ear discomfort or itching
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Throat problem
- ❑ Neck problem
- ❑ Other:_____

Thank you!

Sheepshead Bay 2204 Voorhies Ave., Brooklyn, NY 11235 **Phone:** (718) 646-2500 **Fax:** (718) 648-4583
Bay Ridge 9015 5th Ave., Brooklyn, NY 11209 **Phone:** (718) 745-1701 **Fax:** (718) 745-1720

www.nycent.com

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NOTICE OF PRIVACY PRACTICES --- PATIENT ACKNOWLEDGEMENT

Patient Name:_____Date of Birth:_____

I have received this Practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made of this Practice, my individual rights, and the Practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this Practice is required by law to maintain the privacy of protected health information.
- A statement that this Practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this Practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of ow I exercise their rights in relation to:
    - The right to complain to this Practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restriction on certain uses and disclosures of my protected health information, and that this Practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this Practice upon request.

This Practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this Practice's current Notice of Privacy Practices on request.

Signature:_____Date:_____

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Your signature below constitutes a binding agreement between the NY Center for Ear Nose Throat, Sinus & Allergy and the Patient receiving medical services, or the Responsible Party if the patient is a minor under 18 years of age. All charges for services rendered are due and payable at time of service. We will bill your insurance company as a service to you. As the Responsible Party, you are responsible for payment if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform our practice of the current address and phone number for the Patient and Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at time of visit.Pay any additional amounts from prior charges.

Should collection proceedings or other legal actions become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that NY Center For Ear Nose Throat, Sinus & Allergy has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. By signing below you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient or Responsible Party Name (Please Print)_____

Patient or Responsible Party Name Signature_____

Date_____

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MEDICAL INTAKE

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Height:_____ **Weight:**_____

Allergies (Include Allergies To Medications):

_____

_____

MEDICATION LIST:

_____

_____

Current/Chronic Medical Conditions:

- ❑ **NONE**
- ❑ Acid Reflux
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arthritis
- ❑ Asthma
- ❑ Allergies
- ❑ Bleeding/Clotting Disorder
- ❑ Breast Disease
- ❑ Cancer- *Type:* _____
- ❑ Cataracts
- ❑ Chronic Bronchitis/ Emphysema
- ❑ COVID19
- ❑ Diabetes
- ❑ Gallbladder
- ❑ Glaucoma
- ❑ Gynecologic Disorders
- ❑ Lupus
- ❑ Headaches
- ❑ Heart Attack- *Date:*_____
- ❑ Heart Disease
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Irregular Heart Rhythm
- ❑ Kidney Disease
- ❑ Migraine
- ❑ Pneumonia
- ❑ Rheumatoid Arthritis
- ❑ Sarcoidosis
- ❑ Seizure/Epilepsy
- ❑ Skin Disease (*Eczema/Psoriasis*)
- ❑ Stroke- *Date:* _____
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers

Other Medical Conditions: _____

Past Surgeries (Type & Year):_____

Check the following that apply:

- ❑ **Tobacco- Packs Per Day:** _____ **Years Smoked:** _____
- ❑ **Alcohol Use-** *check one*→ **Socially:** _____ **Weekly:** _____ **Daily:**_____

Patient Signature: _____ **Date:** _____

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