Welcome to Dagan MD NYC a Premiere ENT Allergy Hearing and Balance Cosmetic Surgery practice. Please take the time to fill out our forms so we can provide you top quality service.

Patient Registration

Name: (*Last*) (*First*)

Street Address **APT/SUITE#** **City** **State** **Zip Code**

( ) *Home / Cell* ( )
Main contact telephone number (*Please circle*) **Work Phone**

Date of Birth (*Month / Day / Year*) **Contact E-mail:**

Male / Female *Single / Married / separated / Divorced / widowed*
Sex (*Please circle*) **Age** **Marital Status** **Social Security**

Occupation **Employer Name and Address**

Emergency Contact (*Last Name*) (*First Name*) **Tel # (1)** **Tel # (2)** **Relationship**

Family Physician Name **Tel #** **Date of Last Exam**

HOW DID YOU HEAR OF DAGAN MD NYC? (*Please Circle and provide referring physician name*)

Referred by: *Physician Friend Yellow Pages Zoc Doc TV/Radio Internet Newspaper Other:*_______________

Pharmacy Name **Telephone#** **Cross Street**

YES NO
Primary Insurance Carrier **Policy#** **Specialist Co-Pay ($)** **Referrals Needed** (***Please Circle***)

DAGAN MD NYC
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(   )

Health Insurance: Tel # **Group#** **Insurance Address**

Do you have a FSA/HAS Acct. (N) If yes, does your employer contribute towards your Copay/Deductible/Co-insurance? (Y)

Name (*Last*) (*First*) **Today's Date** (*Month / Day / Year*)

Patient Medical History

Specific reason for visit/Consultation (*please enter all the reasons for your visit with the doctor today*)

Height________ **Weight**_______

Allergies: (*List* ***ANY*** *reactions you have had to medications and describe the symptoms*)

Medications :(*List* ***ALL*** *prescription, over-the-counter & herbal medications you have taken recently with dosages*)

Past Medical History: (*List* ***ANY*** *medical conditions for which you have been treated*)

Past Surgical History: (*List* ***ALL*** *previous surgery; include complications or abnormal reactions to anesthetics*)

Social History

Yes / No Yes / No

Exercise (*times per week*) Cigarette Smoking (pack (s) per day) for _____years Quit

□None □ Social □ Heavy Yes / No □None □ Social □ Heavy

Alcohol Coffee Cups/day Drug Use (substance/s) w

Are you currently pregnant? Yes No If yes, how many months? _____

Family History: (*check any of the following that effect first degree relatives and relation):*

□Anesthetic Problems □ High Blood Pressure □ Heart Disease □Breast Cancer □ Diabetes

□Bleeding Disorders □Mental Illness □Hereditary Diseases □ Other: __________________

Past history of illness or conditions (*Please circle*)**:**

Diabetes Glaucoma Heart trouble High blood pressure Chicken pox Cancer Asthma Jaundice Gonorrhea
Antibiotic use Mumps Pneumonia Allergies Kidney disease Bleeding tendencies Rheumatic fever Anxiety

Measles Syphilis Multiple Sclerosis Infectious Mononucleosis High fevers Tuberculosis Hepatitis Polio
Gonorrhea Vein Trouble HIV Other: ____

Are you currently receiving care from a (*Please Circle*)**:**

□Chiropractor □Acupuncturist □Medical specialist □Dentist □Physical Therapist □Massage

□Therapist □Nutritionist □Surgical Specialist Other

Comments: ____

Name (*Last*) (*First*) **Today's Date** (*Month / Day / Year*)

PERSONAL MEDICAL HISTORY

CHECK ALL THAT APPLY:

GENERAL
___ fatigue
___ swollen glands
___ hot or cold intolerance
___ frequent headaches
___ weight loss / gain
___ fever or chills
___ allergies
___ nervousness
___ depressed
___ irritable

SLEEP
___Daytime fatigue
___insomnia/Sleep problems
___Snoring

NERVOUS SYSTEM
___ dizziness
___ blurred vision
___ fainting
___ paralysis
___ tremors
___ numbness/tingling
___ convulsions
___ imbalance

NECK
___ pain in neck
___ neck pain w/movement
___ pinched nerve in neck
___ neck feels out of place
___ stiff neck
___ muscle spasms in neck
___ popping sounds in neck
___ arthritis in neck

HEAD
(headache: note which area)
___ entire head
___ back of head
___ forehead
___ temples
___ migraine
___ head feels heavy
___ loss of memory
___ light-headedness
___ fainting
___ light bothers eyes
___ loss of smell
___ loss of taste
___ loss of balance
___ dizziness
___ loss of hearing
___ pain in ears
___ buzzing in ears

ENT
___ earache
___ ear discharge
___ ringing in ears
___ hearing loss
___ nosebleeds
___ hoarseness
___ problems swallowing
___ sore throat
___ jaw tight or sore
___ dental problems
___ glasses/contacts

SKIN
___ easy bruising
___ dry skin

___ itching
___ boils
___ rashes
___ excessive sweat
___ hair changes

HEART/LUNG
___ chest pain
___ high blood pressure
___ low blood pressure
___ persistent cough
___ hard to breathe
___ coughing blood
___ coughing phlegm
___ irregular heartbeat
___ varicose veins
___ ankle swelling

GASTROINTESTINAL
___ change in appetite
___ thirst
___ nausea
___ vomiting

___ diarrhea
___ constipation
___ gas
___ hemorrhoids
___ gall bladder
___ abdominal pain
___ bloody/black stools
___ indigestion
___ liver trouble
___frequent throat clearing
___Foreign body sensation in throat in the morning
___ belching
___ heartburn

Epworth Sleepiness Scale *Choose the most appropriate response for each situation* →	**Never would doze off**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
1. Sitting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Laying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking with someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
Score of All Questions (sum total of all eight responses):				

DAGAN MD NYC

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IN-OFFICE PROCEDURES

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware separately and in addition to office visit charges. We have become aware that some insurance carrier are classifying these procedures as "Surgery" and applying the charges to your calendar year deductible. The results may be insurance payment for an office visit but **NOT** a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines.

The physicians of **Dagan MD** only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus or throat/voice compliant, there is a good chance the surgeon will need to perform one of these procedures.

Example of in-office procedures include:

- CPT-31575 Flexible Laryngoscopy

This procedure involves passing a long thin flexible fiber-optic-scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize area of the throat not readily seen using laryngeal mirrors.

- CPT-31231 Nasal Endoscopy

This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

- CPT-31231 Nasal Endoscopy with Debridement or Biopsy

This is the same procedure as above with removal of crusting or tissue.

- CPT-92511 Flexible Nasopharyngoscopy

This involves examining both the tissues of the nasal passages and the pharynx and larynx.

Please speak with the office manager or front desk receptionist if you would like to what your carrier allows for these procedures prior to their completion.

Patient Name (please print): ____

Patient/Guardian Signature: ________________________________ Date: _______________

NOTICE

Cancellation Policy

Please be advised of our cancellation policy.

The fee for all cancellations is *$100* **UNLESS** this office is notified at least **24 hours** prior to the appointment. In the event of a true emergency, exceptions can be made.

Please understand that another patient may be able to use your cancelled slot.

Thank you.

Date___________________________

Signature____

Your Signature Is Necessary For Us To Process Any
Insurance Claims And To Ensure Payments Of Services Rendered.

<u>All Private Insurance</u>

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/ or surgical benefits, including major medical benefits to which I am entitled, to the provider of services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid as the original.

<u>The Medicare Patient</u>

I request the payment of authorized Medicare benefits be made to me or on my behalf to the provider for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for released services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCLUDING BUT NOT LIMITED TO ANY MEDICAL RELATED FEES AND ANY FEES INCURED IN COLLECTION OF ANY OUTSTANDING BALANCE INCLUDING ATTORNEY FEES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

I understand that in the case my insurance provider issues payment for any service rendered by Dr. Tal Dagan or any of his employees, that payment shall be sent promptly to Dr. Dagan. In the case payment issued for services by Dr. Dagan or his employees is not forwarded within one month, I will be responsible for the payment amount and any legal cost necessary to procure payment in addition to accrued interest at 25%.

PATIENTS NAME: (PRINT) ____

DATE: _________________________________

PATIENTS SIGNATURE: ____
(OR RESPONSILLE PARTY OF MINOR)

To all our new and established patients,

We appreciate and respect that you have chosen to receive medical service at our practice. Many insurance plans now place a higher burden on their members, requiring higher copayments, coinsurances and deductibles depending on the type of service. Furthermore, when we verify your coverage, your insurance company will not guarantee the information they provide us is accurate and up to date, nor would they guarantee payment for a particular service. As a result, we have implemented a new policy for the office which now requires all patients to provide us with a valid credit card number prior to services being rendered.

You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance has paid their portion and notified us of the amount of your share of the claim. At that time you will receive an invoice that will show any remaining balance owed by you. If we do not hear back from you within 90 days of receiving the first invoice, our office will call you to inform you that the remaining balance will be charged to your credit card and a copy of that charge will be mailed to you. You will also receive an explanation of benefits from your insurance company detailing the fee that is your responsibility, so the charge should not come as a surprise to you.

Copayments, previous balances and any remaining deductible due at the time of your visit will, of course, still be due at the time of your visit. We will continue to bill your insurance carrier, but should your insurance company decline to accept responsibility for any part of your visit, we will send you an invoice for the difference.

This will not compromise your ability to dispute a charge, or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask us. I thank you for your understanding of this policy.
Please be advised that all products and services are non-refundable.

Sincerely,

Dr. Tal Dagan

Patient Consent to Credit Card Charges

I__________________________________, authorize Tal Dagan MD, F.A.C.S to charge my credit card for the balance of charges not paid by my insurance carrier (additional copayment, coinsurance or deductible). I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to Dr. Tal Dagan.

__________________________________ __________________

Cardholder signature ***Date***

Patient Name (Last, First):		
Card holder name (as it appears on card):		
Card holder billing address:		
City:	State:	Zip code:
Credit Card number:		Expiration(MM/YY):
CVC:	○Visa ○Master Card ○ American Express ○Other	
Mail Receipt: ○CC Billing Address ○Chart Home Address		

PERSONAL ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that:

I have received and reviewed Tal Dagan MD PC Notice of Privacy Practice.
I understand that I can contact the Practice Privacy Office at (212) 585-3242.

Date: ________________________

Signature of patient/Personal Representative	**Print Name of Patient/ Personal Representative**
____	____