HAMBURG ENT AND FACIAL PLASTICS ASSOCIATES

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St. Catherine of Siena
Huntington Hospital
Stony Brook University Hospital
Manhattan Eye, Ear and Throat

PATIENT INFORMATION

Chart #_____

Name_____
Social Security #_____
Home Address_____
City/State_____
Home Phone _____
Preferred Pharmacy_____
Pharmacy Ph. #_____
Referring Doctor_____
Referring Doctor's #_____
Emergency Contact: Phone #-_____
_____

Date of Birth_____
Sex: ____Male ____Female
Marital Status_____
Cell Phone/Beeper_____
Email_____
Occupation_____
_____
Name of Employer_____
_____
Work Phone #_____
_____

INSURANCE INFORMATION

Name on Card_____
ID # on Card_____
Relationship to Insured_____
Policy Holder's Name_____
Policy Holder's Date of Birth_____
Policy Holder's SS #_____

Insurance Company Name____
_____
_____
Policy Holder's Employer____
_____
Policy Holder's Phone #_____

Secondary Insurance(if applicable)

Name on Card_____
ID # on Card_____
Relationship to Insured_____
Policy Holder's Name_____
Policy Holder's Date of Birth_____
Policy Holder's SS #_____

Insurance Company Name____
_____
_____
Policy Holder's Employer____
_____
Policy Holder's Phone #_____

I verify that the above information is accurate.
X_____**Sign Here**
Today's Date_____

History Form

ALLERGIES TO MEDICATIONS: _____

REASON FOR TODAY'S VISIT: _____

_____

_____

LENGTH OF TIME WITH COMPLAINT: _____

(very important that we know how long you have had symptoms)

OTHER COMPLAINTS:

COSMETIC CONCERNS

Please circle

1. Face/Neck
2. Eyes
3. Nose
4. Ears

EAR/NOSE/THROAT (If ear problem. indicate which ear)

Please circle

Hearing Loss
Ringing in Ears
Dizziness
Swallowing Problems
Hoarseness
Shortness of Breath
Nasal Congestion
Sinusitis
TMJ

PERSONAL HISTORY:

High Blood Pressure
Diabetes
Asthma
Heart Disease
Prior Heart Attack
Prior Stroke
Bleeding Problems
Arthritis
Cancer
Allergy
Smoking
Alcohol/Drug Abuse
Other _____

Height _____ Weight _____

PRESENT MEDICATIONS: _____

SEASONAL INHALANTS: _____

PAST SURGERY: _____

_____

DATE _____

_____
SIGNATURE

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each.

0= no chance of dozing
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total ☐

Patient Signature *Date*

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely. As is require by the new law, we have highlighted the points of interest for your review.

Background:
In 1996, Congress recognized the need for national patient privacy standards and as part of the Health Insurance Portability and Accountability Act (HIPAA), ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans.

Health information is considered sensitive and personal, and the law established consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also, for prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, no consent is needed in the course of carrying out health care operations, such as quality assessment, or in communication with our insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses as long as you are not individually identified.
- You have the right to request the release of your medical information.
- You may suggest additional restrictions with regard to certain used and disclosures, if you wish.
- Portions of this notice may be modified and/or amended per government regulations.
- The law requires that you acknowledge receipt of this notice.

Thank you.

Patient Name: _____

Insurance Company Name and Policy ID:_____

Insured Name _____ Insured DOB _____

Your relationship to the insured:

___ Self ___Parent ___Spouse ___Other _____

I hereby transfer, assign and convey to the above-named Provider (the "Provider"), all of my rights and benefits to which I am entitled regarding payment or reimbursement of claims under my insurance coverage as provided by the above-named insurer (the "Insurer"), as the same may relate to medical services, treatment, care and/or supplies provided to me and/or my dependents by the Provider (collectively, the "Coverage Benefits"). I understand and agree that I am responsible for any amount not covered by my insurance policy.

I further hereby instruct and direct the Insurer to make payment of all Coverage Benefits directly to the above Provider, OR, if my current policy prohibits direct payment to the Provider, I hereby instruct and direct the Insurer to make the check payable to me and mail it to the Provider at the above address.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claim and securing payment of Coverage benefits as required under my policy.

I authorize Provider to initiate a complaint to the Insurance Commissioner if the Insurer fails to comply with my instructions herein or otherwise fails to provide payment for my Coverage Benefits.

I authorize the use of my signature below for all insurance submissions by Provider with respect to my Coverage Benefits

Dated this _____ day of _____, 20_____

Signature of Policyholder:_____

Signature of Claimant, if other than Policyholder:_____

Sleep Solutions
of New York

RICHARD D. HAMBURG, M.D., D.D.S., F.A.C.S.

Diplomate of American Board of Otolaryngology
Diplomate of American Board of Sleep Medicine

I, _____ acknowledge the receipt of Dr.

Richard Hamburg's HIPAA privacy notice.

_____ _____

Signature of Patient Date

_____

Signature of Parent/Guardian (if applicable)