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Patient's Last Name _____ First Name _____ Middle Initial ____

SSN (Optional) _____ Date of Birth _____ Age _____ Sex: F M

Address _____ Apt.# _____ City _____ State _____ Zip _____ County _____

Race: _____ Language: _____

Name & Address of Primary Care (Family) Physician _____

Referring Physician Name & Address (if different) _____

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ ☐ Retired?

Name of Spouse/Parent/Legal Guardian _____ DOB _____ SSN _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Is this visit covered by Workers' Comp? _____ No Fault? _____

Emergency Contact: _____ Phone #: _____

Doctor you are here to see _____ I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I have received notice of privacy practice.

Responsible Party Signature: _____ *Date:* _____

Patient Name: _____ DOB: _____ Date: _____

What is the reason you are here today? _____ _____

How long have you had the problem for # of days____ # of weeks____ # of years____

ALLERGIES? ☐ No Allergies

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or

Larry J. Shemen, M.D FRCS (C) to obtain medication history via electronic means directly from insurer/pharmacy _____initial here

☐ No Current Medications

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone) _____

Preferred Lab: (circle one or indicate 'other') Quest Labcorp Other _____

MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?

☐ No Medical / Surgical History

Cardiovascular:	Yes	Surgery/Management
Coronary Artery Disease	☐	_____
Elevated Cholesterol (hyperlipidemia)	☐	_____
High Blood Pressure (hypertension)	☐	_____
Gastrointestinal:		
Hepatitis	☐	_____
Hernia	☐	_____
Gastroesophageal Reflux	☐	_____
Genitourinary:		
Prostate enlargement (Benign Prostate Hyperplasia)	☐	_____
Kidney Stones (Nephrolithiasis)	☐	_____
Renal Failure (Acute)	☐	_____
Ear / Nose / Throat: (HEENT)		
Cataracts	☐	_____
Glaucoma	☐	_____
Chronic Ear Infections (Otitis Media)	☐	_____
Hearing Loss	☐	_____
Sinus Problems (chronic sinusitis)	☐	_____
Nasal Polyps	☐	_____
Nasal Allergies	☐	_____
Recurrent Tonsillitis	☐	_____
Tinnitus	☐	_____
Vertigo	☐	_____
Hematologic :		
Anemia	☐	_____

Immunologic:	Yes	Surgery/Management
Allergies Type: _____	☐	_____
Food Allergies Type: _____	☐	_____
Infectious Disease:		
Mononucleosis	☐	_____
STD Type: _____	☐	_____
Metabolic/endocrine:		
Diabetes Type: _____	☐	_____
Thyroid deficiency (hypothyroidism)	☐	_____
Thyroid excess (hyperthyroidism)	☐	_____
Neoplastic:		
Cancer Type: _____	☐	_____
Neurologic:		
Migraine	☐	_____
Obstetric:		
Pregnancy Date(s): _____	☐	_____
Psychiatric:		
Adjustment Disorder - Anxiety	☐	_____
Major Depression	☐	_____
Pulmonary:		
Asthma	☐	_____
COPD	☐	_____
Emphysema	☐	_____
Sleep Apnea	☐	_____
Tuberculosis	☐	_____

If YES to any of the above Diagnosis was surgery performed'

What_____ Where/When_____ By Who_____

FAMILY HISTORY of:	Who		Who		Who
ADD/ADHD	☐	CVA (Stroke)	☐	Learning disability	☐
Alcoholism	☐	Depression	☐	Mental illness	☐
Allergies	☐	Developmental delay	☐	Migraines	☐
Alzheimer's Disease	☐	Diabetes	☐	Obesity	☐
Asthma	☐	Eczema	☐	Osteoarthritis	☐
Blood disease	☐	Hearing deficiency	☐	Osteoporosis	☐
CAD (Coronary Artery Disease)	☐	Hyperlipidemia	☐	PVD	☐
CAD-Premature	☐	Hypertension	☐	Renal disease	☐
Cancer Type: _____	☐	Irritable Bowel Syndrome	☐	Seizure disorder	☐

Other Family History: _____

Tobacco Use? ☐ Yes ☐ No ☐ Former

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ Yes ☐ No ☐ Former

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ Yes ☐ No

Caffeine Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

No	Yes
☐	☐ Fatigue
☐	☐ Fever
☐	☐ Night sweats
☐	☐ Weight loss
☐	☐ Weight gain

Eye problems

No	Yes
☐	☐ Double vision
☐	☐ Itchy eyes
☐	☐ Redness

Ear problems

No	Yes
☐	☐ Drainage
☐	☐ Hearing loss
☐	☐ Infections
☐	☐ Dizziness
☐	☐ Itchiness
☐	☐ Exposure to Excessive Noise
☐	☐ Ear pain
☐	☐ Ringing /noise in ears

Nose & Sinus problems

No	Yes
☐	☐ Congestion
☐	☐ Facial Pain
☐	☐ Mouth Breathing
☐	☐ Nose Bleeds
☐	☐ Sneezing
☐	☐ Runny Nose
☐	☐ Post Nasal Drainage

Prefe

Mouth & Throat problems

No	Yes
☐	☐ Difficulty Swallowing
☐	☐ Sleep Apnea
☐	☐ Snoring
☐	☐ Sore Throat
☐	☐ Hoarseness
☐	☐ Sores/Ulcers in Mouth

Heart or circulation problems

No	Yes
☐	☐ Heart Murmur
☐	☐ Chest pain
☐	☐ Swelling of Ankles/Edema
☐	☐ Blacking Out
☐	☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems

No	Yes
☐	☐ Cough
☐	☐ Shortness of Breath
☐	☐ Wheezing

Musculoskeletal:

No	Yes
☐	☐ Leg pain

Stomach problems

No	Yes
☐	☐ Abdominal Pain
☐	☐ Constipation
☐	☐ Diarrhea
☐	☐ Heartburn
☐	☐ Nausea
☐	☐ Vomiting

Brain or Nervous system problems

No	Yes
☐	☐ Headache
☐	☐ Seizures
☐	☐ Focal Weakness
☐	☐ Numbness

Glands & Hormone problems

No	Yes
☐	☐ Heat Intolerance
☐	☐ Cold Intolerance
☐	☐ Neck Enlargement/Goiter

Blood or Lymph nodes problems

No	Yes
☐	☐ Easy Bleeding
☐	☐ Easy Bruising

Allergy problems

No	Yes
☐	☐ Food Allergies
☐	☐ Bee Sting Allergies
☐	☐ Environmental Allergies
☐	☐ Urticaria / Hives

Skin

No	Yes
☐	☐ Itchy Skin/ Pruritis
☐	☐ Rash
☐	☐ Contact Allergy

Height: _____

Weight: _____

Blood Pressure: _____

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- CO-PAYMENTS – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

- OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Larry J. Shemen, M.D for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- SELF-PAY PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- MEDICARE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Larry J. Shemen, M.D FRCS for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Larry J. Shemen, M.D FRCS will not be involved with separation or divorce disputes.

- ALLERGY SHOT PATIENTS – If you are an allergy patient who is consenting to receive allergy shots as part of your treatment plan, it is important that you understand your benefits and responsibilities related to the cost of this type of therapy. Once you consent to receive allergy shots, your doctor will write a prescription for allergy serums specifically for you based on your particular allergies.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security No.
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York and/or New Jersey State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV- related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination be cause of the release or disclosure of HIV-related information, I may contact New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450 or the New Jersey Division on Civil Rights (973) 977-4500. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THEN ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from *(insert date)* _____ to *(insert date)* _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials *Name of individual health care provider*

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
    - ☐ At request of individual
    - ☐ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Head and Neck Surgery

Patient Questionnaire

How did you hear about Dr. Shemen (Please choose only ONE option)?

☐ I did a search on Google and found Dr. Shemen (Or Yahoo, Bing, Yext)

Comment: _____

☐ A Doctor referred me to Dr. Shemen

- Which Doctor referred you to Dr. Shemen?

_____

☐ A Hospital referred me to Dr. Shemen

- Which Hospital referred you to Dr. Shemen?

_____

☐ My Insurance referred me to Dr. Shemen

- Which Insurance Company referred you to Dr. Shemen?

_____

☐ Other: _____

Do you have any comments or recommendations regarding your visit?

_____

_____

For Internal Use: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____