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ROD KACK, M.D.
MARILYN RIGHETTI, M.D.

Date: _____

Welcome to our office...

Who referred you to our office: ❑ Friend ❑ Physician ❑ Yellow Pages ❑ ER Other: _____

PATIENT HISTORY

Referring Physician: _____

Patient's Last Name First Middle				Home Phone	Cell Phone	
Mailing Address City State Zip				Birth Date	Age	Sex Male
Social Security Number	Marital Status Select One			Occupation		
Employer	Work Phone	Business Address City State Zip				
Spouse or Responsible Party's Last Name First Middle				Home Phone	Cell Phone	
Social Security Number		Occupation				
Employer	Work Phone	Business Address City State Zip				
Emergency Contact Other Than Person Above		Relationship		Phone		

INSURANCE

PRIMARY	SECONDARY
Plan Name: _____	Plan Name: _____
Group#: _____	Group#: _____
Policy#: _____	Policy#: _____

There will be a $3 charge for repeat billing and interest after 10 days.
MISSED APPOINTMENTS without 24 hour notice are subject to $20 fee.

CREDIT POLICY: I understand that I am financially responsible for my account regardless of my insurance and for any charges which are either for medical care not covered by my policy or a result of not following the required procedures of my health plan. All charges are due and payable at the time of service unless otherwise specified by an insurance company that is contracted with us.

_____
Signature

_____
Date

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical information necessary to process this claim and request payment of medical benefits be made directly to this physician unless payment is made in full at time of service. There possibly will be a charge for processing a claim for insurance purposes. I also understand that it may be necessary for me to bill my own insurance company directly.

Patient Health History

Last Name	**First**	**Initial**
Age **Birth Date**	**Date Of Last Physical Examination**	
Reason For Today's Visit		

Allergies: To Medications or Substances	**Medications:** List medications you're currently taking.
❑ No Known Drug Allergies	

Surgeries/Hospitalizations: (List All)

Year	Hospital	Reason For Surgery or Hospitalization

Health Habits:

Check (☑) which substances you use and describe how much you use.

☐ Tobacco How Much:_____	☐ Alcohol How Much:_____

Date of last menstrual period: _____ Number of Children: _____

Are you pregnant? ☐ Yes ☒No

Rev: 02/12

Family History: Fill in Health information about your family.

Relation	Age	State of Health	Cause of Death	Check (☑) if you or your blood relative have had any of the following: Disease:	Relationship to you:
Father				Anesthesia Problems	
Mother				Asthma	
Brothers				Bleeding Disorders	
				Cancer (What Type)	
				Diabetes	
				Hay Fever	
Sister				Heart Disease	
				High Blood Pressure	
				Kidney Disease	
				Stroke	
				Other…	

Have you ever had a blood transfusion? ☐ Yes ☐No Year_____

Conditions: Check (☑) conditions you have or have had in the past.

☐AIDS	☐Diabetes	☐High Cholesterol	☐Rheumatic fever
☐Alcoholism	☐Emphysema	☐HIV Positive	☐Scarlet fever
☐Anemia	☐Epilepsy	☐Kidney Disease	☐Sleep Apnea
☐Arthritis	☐Glaucoma	☐Liver Disease	☐Stroke
☐Asthma	☐Goiter	☐Measles	☐Thyroid Problems
☐Bronchitis	☐Gout	☐Migraine Headaches	☐Tonsillitis
☐Cancer	☐Disease Heart	☐Mononucleosis	☐Tuberculosis
☐Cataracts	☐Hepatitis	☐Obstructive Sleep Apnea	☐Typhoid Fever
☐Drug Addiction	☐Herpes	☐Prostate Problem	☐Ulcers
☐Chicken Pox	☐High Blood Pressure	☐Psychiatric Care	☐Venereal Diseases

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I made in completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____ understand that as part of my health care, Snake River ENT Clinic PC originates and maintains paper and/or electronic records describing my health history, symptoms examination and test results, diagnoses, treatment, and any plans for the future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Snake River ENT Clinic PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Snake River ENT PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Snake River ENT PC change their notice, they will give a revised notice to the patient upon the next office visit.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I agree that the following individual(s) _____Relationship(s) _____ may have access to my Protected Health Information, including lab or test results, and diagnosis.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ☐ **accept** ☐ **decline** the terms of this consent.
(Choose One)

_____ _____
Patient's Signature Date

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FOR OFFICE USE ONLY

( ) Consent received by _____on_____.
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical record on_____