ENT, ALLERGY & SINUS PRACTICE

Ran Y. Rubinstein, MD

«Practice_Address1»«Practice_City»«Practice_State»«Practice_ZipCode»

845-562-6673 FAX: «Practice_Fax»

Welcome to Our Office

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.

Name:			Chart #
Address:		City/State/Zip:	
SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:	Work Ph:	Cell Ph:	Pager:
Fax:	Email:	Other Contacts:	
Employer:	Address:		
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name:			Relationship:
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us: «Person_Referral_Source»			
If patient is a child, who may authorize treatment:			Relationship:
Person financially responsible for treatment if not Self:			
Address of person financially responsible:			Phone:
Method of Payment:	Cash	Credit Card - MC Visa # ________________	If insurance, complete below

Insured Party Primary: Insured Party DOB: «Person_Primary_BirthDate»	Address:	
Primary Ins:	Policy No:	Group No:
Insured Party Secondary: Insured Party Secondary DOB:	Address:	
Secondary Ins:	Policy No:	Group No:
If Workers Compensation, treatment authorized by:		Claim #:
If you authorize release of your medical information to anyone besides your insurance carrier, please give the name:		
If you have a telephone answering machine at home, may we leave messages there: YES NO		

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature:	Date:

ENT, ALLERGY & SINUS PRACTICE

845-562-6673(Ph) info@YourFaceMD.com

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so.
Please answer all questions to the best of your knowledge.

Name: ____________________ Reason for Visit: ____________________

Age: __________ Height: ______ Feet ______ Inches Weight: ________ Lbs.

Current Physician(s): ____________________ Date of last physical exam: ____________

Current Ophthalmologist: Date of last exam

Pharmacy Information:

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	GERD-acid reflux	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes	History of allergy shots	No	Yes

Do you smoke? No Yes If yes, how much? ______ Pack(s)/day How long? ______ Years

Do you drink alcohol? No Yes If yes, how much? __________ How often? __________

Do you/did you ever take Accutane Yes No How Long? When did you stop?

Do you use recreational drugs? No Yes If yes, describe: __________

Do you have bleeding or bruising problems? No Yes If yes, describe: __________

Do you have problems with scarring? No Yes If yes, describe: __________

Do you have any history of problems with anesthesia? No Yes If yes, describe: __________

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature ______________________________ **Date** ______________

Ran Y. Rubinstein, MD
Donovan Rosas, MD
200 Stony Brook Court
Newburgh, New York 12550

Welcome to the practice, which is owned by Ran Y. Rubinstein, MD.

Your Surgeon/Physician: We would like you to know that Dr. Rubinstein is board certified by the American Board of Facial Plastic Surgery, American Board of Otolaryngology-Head and Neck Surgery and a Fellow of the American Academy of Otolaryngic Allergy. After completing four years of medical school at Albert Einstein College of Medicine and five years of residency in otolaryngology/head and neck surgery at the University of Medicine and Dentistry at New Jersey, he went on to complete an intensive fellowship training in Facial Plastic Surgery at the University of South Florida in Tampa. Dr. Rubinstein's board certifications, his extensive experience, his commitment to the highest standards, and his role in university education assure you that you could not be in better, more caring hands when having facial plastic surgery. Dr. Rubinstein has been in practice since 1999 and is licensed in the State of New York. You may request his C.V. which we keep on file. Should you choose to have your surgery at this organization Dr. Rubinstein will be the only one performing your surgery.

Your Anesthesia Provider: Additionally, this organization utilizes Board Certified credentialed anesthesia providers, with many years of experience and training licensed in the State of New York.

The Team: Our team is made up of competent, individuals such as RNs licensed in New York that will assist in providing safe patient care.

Should you have a problem: Please be advised that if you have a grievance or concern the following mechanism exists: Ask for the grievance form from the receptionist. Or you may call the organization that oversees our compliance with standards of care The Joint Commission on Accreditation of Healthcare Organizations at 800-994-6610 or email complaint@jcaho.org .

Make a suggestion: If you have a suggestion, please place this in writing and hand to the receptionist or mail to the office.

Play a part in your care: We encourage all patients to be actively involved in their care, so please speak up and ask questions of anyone in this organization.

Additionally, please be advised that this organization does not recognize Do Not Resuscitate orders or Living Wills. If you have any questions, please see the receptionist. If you have a living will or other directive that you would like us to keep a copy of please provide us with a copy of that directive.

Infection Control: This practice educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth when coughing or sneezing and then wash their hands.
Should you have a procedure or surgery in this organization we want you to know that we value patient safety. Therefore you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or a "time out" before we actually start your procedure to assure once again that we have everything that we need and the entire team is in agreement. Only the physician performing your procedure will mark your surgical site. This organization adheres to strict infection control measures before during and after your procedure including but not limited to: procedural technique, the environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

JOINT COMMISSION ONLY: If anyone has concerns about patient care and safety in the organization, that the organization has not addressed, you are encouraged to contact the organization's management. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994-6610 or emailing complaint@jointcommission.org.

Additionally, please be advised that this organization does not recognize Do Not Resuscitate orders or Living Wills.
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Donovan Rosas, MD
200 Stony Brook Court
Newburgh, New York 12550

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.
- I have received information on/am aware of the **Infection Control measures** utilized by this organization.
- I have received information on/am aware of the **Safety Measures** taken by this organization when a procedure is planned.
- I have received a copy/am aware of the **Practice Disclosure** (about our Practice, including the Grievance process) and am comfortable with that information. I also understand this practices position on Do Not Resuscitate (DNR) and Living Wills and that this practice does not honor these directives.

Signature of Patient/Representative______________________________**Date**_________________

Above signature was not obtained because:

☐ **Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.**

☐ **Patient refused to sign.**

☐ **Patient refused forms.**

Additionally, please be advised that this organization does not recognize Do Not Resuscitate orders or Living Wills.
If you have any questions, please see the receptionist.

Tel (845) 562-6673 . Fax (845) 839-2722 . info@YourFaceMD.com . www.YourFaceMD.com

Ran Y. Rubinstein, MD
200 Stony Brook Court
Newburgh, New York 12550

Credit Card Authorization Form

Patient Name: ________________________________ Date of Birth: ____________

The purpose of this form is to authorize ENT Allergy and Sinus Practice to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

ENT Allergy and Sinus Practice reserves the right to charge the credit card listed below for any charges not covered by your insurance and a receipt will be sent directly to you. This notice serves as your consent to being charged for all current patient balances on your account.

If you, as the patient receive a Fee for Service, this includes office visits, procedures and other services not covered by your insurance, ENT Allergy and Sinus Practice reserves the right to charge the credit card listed below the cost of the services rendered.

Other than the conditions mentioned above, under NO circumstances will ENT Allergy and Sinus Practice charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:
Having read this form my signature below acknowledges that I voluntarily give my authorization and consent providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X ______________________________ __________ X __________________ __________
Patient Signature Date Staff Signature Date
(or person authorized to sign for patient)

Name as it appears on Credit Card: ____
Billing Address: ____

Discover/Mastercard/Visa/American Express Card # ________________________________
Expiration Date: ____/_____ Verification Code (3 or 4 digits on back of card): ______

Laser & Cosmetic Surgery Specialists, PC
ENT, Allergy & Sinus Practice
Tel (845) 562-6673 . Fax (845) 839-2722
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www.YourFaceMD.com

Triple Board Certified
Facial Plastic & Reconstructive Surgery
Otolaryngic Allergy
Otolaryngology-Head and Neck Surgery

ENT, ALLERGY & SINUS PRACTICE **845-562-6673(Ph) info@YourFaceMD.com**

(Please Print Legibly & Fill In or Correct All Fields)

«Person_Last_Name», «Person_First_Name»

<u>* Complete this form ONLY IF you have any sinus issues (nose problems) *</u>

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient Name: ______________________

Sino-Nasal Outcome Test (SNOT-20)

Date: ______________________

1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. 2. Please mark the most important items affecting your health (maximum of 5 items).	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		○
2. Sneezing	0	1	2	3	4	5		○
3. Runny nose	0	1	2	3	4	5		○
4. Cough	0	1	2	3	4	5		○
5. Post-nasal discharge	0	1	2	3	4	5		○
6. Thick nasal discharge	0	1	2	3	4	5		○
7. Ear fullness	0	1	2	3	4	5		○
8. Dizziness	0	1	2	3	4	5		○
9. Ear pain	0	1	2	3	4	5		○
10. Facial pain / pressure	0	1	2	3	4	5		○
11. Difficulty falling asleep	0	1	2	3	4	5		○
12. Wake up at night	0	1	2	3	4	5		○
13. Lack of sleep	0	1	2	3	4	5		○
14. Wake up tired	0	1	2	3	4	5		○
15. Fatigue	0	1	2	3	4	5		○
16. Reduced productivity	0	1	2	3	4	5		○
17. Reduced concentration	0	1	2	3	4	5		○
18. Frustrated / restless / irritable	0	1	2	3	4	5		○
19. Sad	0	1	2	3	4	5		○
20. Embarrassed	0	1	2	3	4	5		○

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