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 or	ffice In order	to corve you pro	norly E	DI EASE DDINT the fo	allowing in	formation		
Name:	ince. In order	to serve you pro	perry, r	LEASE FRINT HIE IC	onowing in	Chart #		
rame.				Chart #				
Address:				City/State/Zip:				
SSN:	Birthdate:			Marital Status:		Gender:		
Home Ph:	Work Ph:			Cell Ph:		Pager:		
Tionic I ii.	WOIK I II.			Cen i ii.		1 agot.		
Fax:	Email:			Other Contacts:				
				Outer Contacts.				
Employer:	A	Address:						
Occupation:				Full/Part/Student/	Retired/O	ther:		
Emergency Contact Name:						Relationship:		
ER Contact Home Ph:				ED Contact Work	Dh.	1		
ER Contact Home Pn:				ER Contact Work	Pn:			
How did you hear about us:	«Person_Re	eferral_Source»						
If patient is a child, who ma	v authorize t	reatment:				Relationship:		
,								
Person financially responsib								
Address of person financial	ly responsible	e:		Phone:				
Method of Payment: Car	sh Credit	Card - MC Vis	sa #	If insurance, complete below				
Insured Party Primary:			Address	· ·				
insured raity rinnary.		1	raar est	·				
I ID (DOD n	D. D. 15							
Insured Party DOB: «Person_Primary_BirthDate» Primary Ins: Policy No:				Grou	n No:			
Filliary IIIs.		Folicy No.		Group No:				
Insured Party Secondary:				Address:				
Insured Party Secondary Do	OB:							
Secondary Ins: Policy No:				Group No:				
,		,			1			
If Workers Compensation, treatment authorized by: If you authorize release of your medical information to anyone besides			i dos	1		Claim #:		
your insurance carrier, please giv		tion to anyone besi	iaes					
If you have a telephone ans		ine at home, ma	ay we lo	eave messages there	: YES	NO		
<u> </u>								
I authorize this office to rele								
payment: I understand that I am responsible for all charges, regardless of insurance coverage.								

Date:

Patient, Parent or Guardian Signature:

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

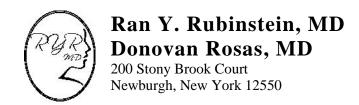
(Please Print Legibly & Fill In or Correct All Fields)

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	We	eight:		Lbs.
Current Physician(s):					Date of last p				
Current Ophthalmologist:					Date of la	ast exar	n		
Pharmacy Information									
List all Surgeries (Hosp	talization a	and the D	ate of Occur	rence):				
List any Serious Illnesse	es and/or A	Accidents	:						
Do you have or have you	nad any of t	he followi	ng: (circle for	each, g	give date occ	urred if	Yes)		
Aids / HIV No	Yes	Epilepsy / Seizures		No Yes		Kidney Problems		No	Yes
Arthritis No	Yes	Facial Pair	า	No	Yes	Pneumonia		No	Yes
Asthma No	Yes	Fever Blist	ers	No	Yes	Sinus P	roblems / Infections	No	Yes
Bronchitis No	Yes	Yes Goiter / Thyroid			Yes	Stroke		No	Yes
Cancer No	Yes	Yes Hay Fever / Allergies			Yes	Tonsillitis		No	Yes
Depression No	Yes	Yes Headaches / Migraine			Yes	Tuberculosis		No	Yes
Diabetics No	Yes	Yes Heart Trouble			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 muc		Pack(s		s)/day How long?			Years
Do you drink alcohol? No Yes If yes, how much? How often?									
Do you/did you ever take	No Ho	w Long	g?	Wh	en did you stop?				
Do you use recreational drugs? No Yes If yes, describe:									
Do you have bleeding or bruising problems? No			Yes	If ves	s, describe:				
Do you have problems with scarring?		No	Yes	If yes, describe:					
Do you have any history of problems			. 00	If yes, describe:		-			
		No	Yes						
List the name of all med	lications vs	NI Oro pr	ocently takin	a or b	avo tokon w	ithin th	a last month. D	0000	include the
name of the drug, dosage			eseritiy takiri	g or m	ave lakeli w	111111111111	e iasi montii. Fi	case	include the
marrie of the drug, dood,	go ana noc	quority.							
List ALL drug and/or lat	ex allergies	S.							
The above information	is accura	ate and c	omplete to	the be	est of my ki	nowled	dge.		

Date

Signature



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.

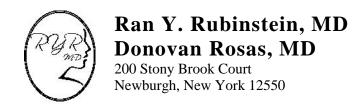
Infection Control: This practice educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth 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.

If you have any questions, please see the receptionist.



PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

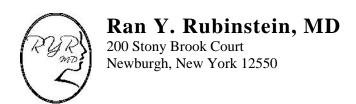
My signature below acknowledges the following:

- 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 representate pertinent disclosures.	tive. Patient left with all
□ 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.



Credit Card Authorization Form

Patient Name:		Date of Birth:	
The purpose of this form is to auth number on file for you as our pati will have access to the informatio	ent. This form will		
Your supplied credit card will be	charged ONLY und	er the following circumstance	ces:
ENT Allergy and Sinus Practice r charges not covered by your insur your consent to being charged for	rance and a receipt w	ill be sent directly to you. T	<u>-</u>
If you, as the patient receive a Fee not covered by your insurance, El card listed below the cost of the se	NT Allergy and Sinu		
Other than the conditions mention Practice charge your credit card for HIPPA regulations, all credit card our office. Only authorized staff	or anything not discu information will be	ssed personally with you. I confidentially kept within y	n conjunction with
Acknowledged, Agreed & Acce Having read this form my signatu consent providing the requested in conditions listed above.	re below acknowled		
X		X	
Patient Signature (or person authorized to sign fo	Date	Staff Signature	Date
Name as it appears on Credit Card Billing Address:	d:		
Discover/Mastercard/Visa/Americ Expiration Date:/			k of card):

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

«Person_Last_Name», «Person_First_Name»

* Complete this form ONLY IF you have any sinus issues (nose problems) *

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.

inc	no-Nasal Outcome Test (SNOT-20) Date:									
2. 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. 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	0		
2.	Sneezing	0	1	2	3	4	5	0		
3.	Runny nose	0	1	2	3	4	5	0		
4.	Cough	0	1	2	3	4	5	0		
5.	Post-nasal discharge	0	1	2	3	4	5	0		
6.	Thick nasal discharge	0	1	2	3	4	5	0		
7.	Ear fullness	0	1	2	3	4	5	0		
8.	Dizziness	0	1	2	3	4	5	0		
9.	Ear pain	0	1	2	3	4	5	0		
10.	Facial pain / pressure	0	1	2	3	4	5	0		
11.	Difficulty falling asleep	0	1	2	3	4	5	0		
12.	Wake up at night	0	1	2	3	4	5	0		
13.	Lack of sleep	0	1	2	3	4	5	0		
14.	Wake up tired	0	1	2	3	4	5	0		
15.	Fatigue	0	1	2	3	4	5	0		
16.	Reduced productivity	0	1	2	3	4	5	0		
17.	Reduced concentration	0	1	2	3	4	5	0		
18.	Frustrated / restless / irritable	0	1	2	3	4	5	0		
19.	Sad	0	1	2	3	4	5	0		
20	Embarrassed	0	1	2	3	4	5	0		

@1996 by Jay F. Picirillo, M.D., Washington University School of Medicine, St. Louis, Missouri