PATIENT'S INFORMATION

NAME: ______________________________ (LAST NAME) ______________________________ (FIRST NAME)

ADDRESS: ______________________ CITY: __________ STATE: ______ ZIP: ______ COUNTRY: ______

TELEPHONE: HOME ( ) ______________________ DATE OF BIRTH: ______________________

EMPLOYER: ______________________ SOCIAL SECURITY NUMBER: ______________________

EMPLOYER ADDRESS: ______________________ (CIRCLE ONE) MALE FEMALE

CITY: __________ STATE: ______ ZIP: ______ MARITAL STATUS: S M W D SP

TELEPHONE: WORK ( ) ______________________

EMERGENCY CONTACT

NAME: ______________________ TELEPHONE NUMBER: ______________________

REFERRING PHYSICIAN

REFERRING PHYSICIAN: ______________________ TELEPHONE NUMBER: ______________________

PRIMARY INSURANCE

(COPY OF INSURANCE CARD IS REQUIRED)

NAME OF INSURANCE COMPANY: ______________________

ADDRESS OF INSURANCE: ______________________ CITY: __________ STATE: ______ ZIP: ______

ID OR POLICY NUMBER: ______________________ GROUP NUMBER: ______________________

EFFECTIVE DATE OF INSURANCE: ______________________

WHO IS SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE PARENT OTHER

IF SUBSCRIBER IS OTHER THAN SELF – COMPLETE THE FOLLOWING:

SUBSCRIBER'S NAME: ______________________ (CIRCLE ONE) MALE FEMALE

STREET ADDRESS: ______________________ CITY: __________ STATE: ______ ZIP: ______ COUNTRY: ______

DATE OF BIRTH: ______________________ SOCIAL SECURTITY NUMBER: ______________________

SECONDARY INSURANCE

(COPY OF INSURANCE CARD IS REQUIRED)

NAME OF INSURANCE COMPANY: ______________________

ADDRESS OF INSURANCE: ______________________ CITY: __________ STATE: ______ ZIP: ______

ID OR POLICY NUMBER: ______________________ GROUP NUMBER: ______________________

EFFECTIVE DATE OF INSURANCE: ______________________

WHO IS SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE PARENT OTHER

IF SUBSCRIBER IS OTHER THAN SELF – COMPLETE THE FOLLOWING:

SUBSCRIBER'S NAME: ______________________ (CIRCLE ONE) MALE FEMALE

STREET ADDRESS: ______________________ CITY: __________ STATE: ______ ZIP: ______ COUNTRY: ______

DATE OF BIRTH: ______________________ SOCIAL SECURTITY NUMBER: ______________________

AUTHORIZATION INFORMATION
(ASSIGNMENT OF BENEFITS)

I hereby assign to ______________________ any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under by "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned o this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and / or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

SIGNATURE: ______________________ **DATE:** ______________________

FOR RELEASE OF INFORMATION

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

SIGNATURE: ______________________ **DATE:** ______________________

MEDICAL HISTORY ИСТОРИЯ БОЛЕЗНИ

1. When was your last physical exam?
Когда Вы обследовались у врача последний раз?
____

2. Physician's Name Фамилия терапевта ______________
Phone Телефон ______________

	Yes	No
3. Are you currently under medical treatment? Please describe / Вы проходите курс лечения в настоящее время? Опишите, пожалуйста ______________	☐	☐
4. Have you ever had any serious illnesses or operations? / Вы когда-либо серьезно болели, Вас оперировали? Please describe Опишите, пожалуйста ______________	☐	☐
5. Are you currently taking any medication? Please describe / Вы принимаете лекарства в настоящее время? : Опишите, пожалуйста ______________	☐	☐
6. Do you smoke? Вы курите?	☐	☐
7. Do you use alcohol, cocaine or other drugs? / Вы употребляете алкоголь, кокаин или другие наркотики?	☐	☐

8. Have you had any allergic reactions to the following:
У Вас есть аллергия на следующие препараты?

Local Anesthetics (eg. Novocaine) / Местный наркоз (например, новокаин)	☐	☐
Penicillin or other Antibiotics / Пенициллин или другие антибиотики	☐	☐
Sulfa Drugs / Аллергия на морепродукты	☐	☐
Barbiturates (sleeping pills) / Лекарства от бессонницы	☐	☐
Sedatives / Успокоительные	☐	☐
Iodine / Йодистые	☐	☐
Aspirin / Аспирин	☐	☐
Other / Другие	☐	☐

Please describe: Опишите, пожалуйста ______________

9. Women Only: Только для женщин:

Do you have regular periods Регулярна ли менструация?	☐
Are you taking birth control pills? Принимаете ли противозачаточные?	☐
Have you ever been pregnant? Вы были беременны когда-нибудь?	☐

Number o Pregnancies Сколько раз? ________

Have you ever had the following:
Вы болели следующими болезнями?

	Yes	No
Anemia Малокровие	☐	☐
Anorexia Отсутствие аппетита	☐	☐
Arthritis Артрит	☐	☐
Asthma Астма	☐	☐
Back Problems Болезни спины	☐	☐
Bleeding Tendency Кровотечение	☐	☐
Blood Disease Заболевания крови	☐	☐
Cancer Рак	☐	☐
Chemical Dependency Зависимость от лекарств	☐	☐
Chemotherapy Химотерапия	☐	☐
Chicken Pox Ветрянка	☐	☐
Circulatory Problems Проблемы с кровообращением	☐	☐
Congenital Heart Lesions Врожденный порок сердца	☐	☐
Cough – persistent or bloody Хронический кашель, Кровохарканье	☐	☐
Diabetes Диабет	☐	☐
Emphysema Эмфизема легких	☐	☐
Epilepsy Эпилепсия	☐	☐
Glaucoma Глаукома	☐	☐
Heart Murmur Шумы в сердце	☐	☐
Heart Disease Болезни сердца	☐	☐
Hepatitis-Type Гепатит	☐	☐
Hernia Грыжа	☐	☐
Herpes Венерический лишай	☐	☐
High Blood Pressure Повышенное давление	☐	☐
HIV / AIDS СПИД	☐	☐
Jaundice Желтуха	☐	☐
Kidney Disease Болезни почек	☐	☐
Low Blood Pressure Пониженное давление	☐	☐
Measles Корь	☐	☐
Migraine Headaches Мигрень	☐	☐
Mitral Valve Prolapse Проблема сердечного клапана	☐	☐
Mumps Свинка	☐	☐
Multiple Sclerosis Рассеянный склероз	☐	☐
Pacemaker Аппарат сердцебиения	☐	☐
Pneumonia Пневмония	☐	☐
Polio Паралич	☐	☐
Prostate Problem Простатит	☐	☐
Psychiatric Care Психические болезни	☐	☐
Respiratory Disease Заболевания дыхательных путей	☐	☐
Rheumatic Fever Ревматизм	☐	☐
Scarlet Fever Скарлатина	☐	☐
Shortness of Breath Задержка дыхания	☐	☐
Sinus Trouble Гайморит	☐	☐
Skin Rash Сыпь	☐	☐
Stroke Инсульт	☐	☐
Thyroid Problems Щитовидная железа	☐	☐
Tonsillitis Гланды	☐	☐
Tuberculosis Туберкулез	☐	☐
Ulcer Язва	☐	☐
Venereal Disease Венерические болезни	☐	☐
Any Other Condition Другие болезни	☐	☐

Please describe: Пожалуйста, укажите: ______________

ASSIGNMENTS AND RELEASE

I hereby authorize payment directly to ______________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges , whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

BORIS L. BENTSIANOV, M.D.
Otolaryngology, Head and Neck Surgery

SIGNATURE ON FILE

I request that payment of autorized benefits be made on my behalf to Dr. Boris L. Bentsianov for services furnished to me by the provider. I understand that I am responsible for any co-pay and/or deductible payments.

I autorized any holder or medical information about me to release any information needed to determine these benefits or the benefits payable or related services.

Patient's name ______________________________

Signature ______________________
Date ______________________

Witness name ______________________________

Signature ______________________
Date ______________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ______________________________ Birthdate ______________

Signature ____

Date ____

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