PRINCETON EYE AND EAR

Adult & Pediatric Otolaryngology - Head and Neck Surgery
Ear Nose & Throat Specialists
Facial Plastic & Reconstructive Surgery

□ Dean Drezner, MD FACS
□ Chetan Shah, MD FACS
□ Caitlin Ervin, Ad\uD
□ Aleen Lee, MD
□ Gregory Smith, MD
□ Paige Aufseeser, AuD
□ Rakesh Patel, MD FACS
□ Samir Undavia, MD
□ Irene Cohen, AuD

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt#: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Birth date: _____ Age: _____ Sex: _____ Cell Phone: _____

Marital Status: _____ Social Security #: _____

If Patient is a minor:

Responsible Party: _____ Relationship: _____ Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____ Email: _____

Nearest Relative's Name: _____ Relative's Phone: _____

Referred By: _____ Phone: _____

Medical Doctor: _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Do you have an advanced directive? Yes □ No □ If yes, please provide a hard copy.

Are there any barriers to care? (ex: language, visual, cultural, etc.) Yes □ No □

If yes, please list: _____

INSURANCE INFORMATION

Please present all insurance ID cards and referrals to the receptionist.

1. I am responsible to provide the referral, where required.
2. I am responsible to provide the payment and co-payment when services are rendered.
3. I understand that I am financially responsible for any balance not covered by my insurance, such as deductible, coinsurance and co-payment.
4. I authorize the release of any medical information necessary to process an insurance claim.
5. I will immediately notify your office of any change in my address, phone number and insurance information.
6. I am responsible to inform you about the complete benefits provided by my insurance.
7. I consent to endoscopy [looking into nose, sinuses, food and wind pipe with camera], audiological (hearing) testing, and vestibular (balance) testing, if applicable.

Patient / Parent / Guardian Signature: _____ Date: _____

CONFIDENTIAL
If you are under 18 years of age, you must be accompanied by an adult

PRINCETON EYE AND EAR

Adult & Pediatric Otolaryngology - Head and Neck Surgery
Ear Nose & Throat Specialists
Facial Plastic & Reconstructive Surgery

Dean Drezner, MD FACS	Aleen Lee, MD	Rakesh Patel, MD FACS
Chetan Shah, MD FACS	Gregory Smith, MD	Samir Undavia, MD
Caitlin Ervin, Ad\uD	Paige Aufseeser, AuD	Irene Cohen, AuD

CONSENT AGREEMENT

I, _____ understand that as part of my healthcare, the Doctor's office originates and maintains health records describing my health history, symptoms, examination and test-results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as a:

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

I understand and I have been provided a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. 1 understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization 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 taken in reliance thereon.

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

_____

_____

_____

_____

I fully understand and accept/decline the terms of this consent.

Patient / Parent / Guardian Signature: _____

Date: _____

CONFIDENTIAL
If you are under 18 years of age, you must be accompanied by an adult