



# Head & Neck Specialty Group of New Hampshire

John M. O'Day, M.D., F.A.C.S.  
Marjorie K. Stock, M.D., F.A.C.S.

Otolaryngology  
Head and Neck Surgery  
Facial Plastic and Reconstructive Surgery  
Allergy  
Audiology  
Hearing Aids

361 High Street  
Somersworth, NH 03878-1407  
Phone: 603-692-4500  
Fax: 603-692-4520

## **I. Patient Information**

Appointment Date: \_\_\_\_\_  
Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Physician you are seeing today: \_\_\_\_\_  
Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ (For updates regarding new services)  
May we call you at work? \_\_Y, \_\_N Can we leave a message for you at work? \_\_Y, \_\_N  
Social Security#: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_  
Preferred Pharmacy (please list town): \_\_\_\_\_  
Primary Care Physician's Hospital: \_\_\_\_\_

## **II. Insurance Information**

Name of Primary Insurance Policy Holder: \_\_\_\_\_  
Name of Primary Insurance: \_\_\_\_\_  
ID# \_\_\_\_\_ Group #: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_

Name of Secondary Insurance Policy Holder: \_\_\_\_\_  
Name of Secondary Insurance: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Social Security: \_\_\_\_\_

Relationship of person bringing patient in today: \_\_\_\_\_

Contact in case of an emergency: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Please list BELOW any family member or other person who may call and request information regarding the above patient.**

**PERSONAL DATA SHEET**

Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Married:  Y,  N Children:  Y,  N

Alcohol use:  never,  less than one a week,  1-2 drinks a week,  daily drink or two,  more than 2 drinks a day

Tobacco use:  Y,  N If yes, how much? \_\_\_\_\_, how many years? \_\_\_\_\_

Allergies:  pollen,  food  animal,  latex,  chemicals (please list)

Medication allergies: \_\_\_\_\_

Do you have any bleeding problems or take any of the following medications: Aspirin, Motrin, Advil, Ibuprofen, Aleve, Ticlid, Coumadin, Warfarin, any prescription arthritis medication?  Y,  N If yes, what? \_\_\_\_\_

Hospitalizations and Surgeries (please list hospital, date, and doctor): \_\_\_\_\_

Active Medical Problems (anything you see a doctor for regularly or take medication for): \_\_\_\_\_

Do you have, or have you ever had:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> heart disease        | <input type="checkbox"/> liver disease       | <input type="checkbox"/> kidney disease  | <input type="checkbox"/> diabetes        |
| <input type="checkbox"/> bleeding problem     | <input type="checkbox"/> stroke              | <input type="checkbox"/> seizure         | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> mono                 | <input type="checkbox"/> eczema              | <input type="checkbox"/> yellow jaundice | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> pneumonia            | <input type="checkbox"/> emphysema           | <input type="checkbox"/> measles         | <input type="checkbox"/> German measles  |
| <input type="checkbox"/> tuberculosis         | <input type="checkbox"/> mumps               | <input type="checkbox"/> chicken pox     | <input type="checkbox"/> syphilis        |
| <input type="checkbox"/> Zoster/shingles      | <input type="checkbox"/> Bell's Palsy        | <input type="checkbox"/> ear surgery     | <input type="checkbox"/> cancer          |
| <input type="checkbox"/> asthma               | <input type="checkbox"/> glaucoma            | <input type="checkbox"/> hypertension    | <input type="checkbox"/> heartburn       |
| <input type="checkbox"/> prostate enlargement | <input type="checkbox"/> anesthesia problems |  | <input type="checkbox"/> HIV disease     |

Please list all medications you currently take with the dose and times per day: **\*This includes herbal, vitamins and all non-prescription products and supplements.**

Medical problems that run in your family (refer to the list above): \_\_\_\_\_

**What are you seeing the doctor for today?**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**EAR, NOSE, THROAT AND ALLERGY QUESTIONNAIRE**

Do you have any of the following problems:

**EARS:**                      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Hearing difficulty:      Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Ringing in ears:        Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Discharge:                Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Pain:                        Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Dizziness:                Yes: \_\_\_\_\_                      No: \_\_\_\_\_

**NOSE:**                      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Unable to breathe through:      Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Bleeding:                      Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Discharge:                      Right side: \_\_\_\_\_      Left side: \_\_\_\_\_

Previously broken:              Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Problems occur in different seasons:      Yes: \_\_\_\_\_      No: \_\_\_\_\_

Snore:                        Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Stops breathing at night:      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

**THROAT:**                      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Hoarseness:                      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Difficulty swallowing:      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Coughing up or

    spitting up blood      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

A lump in the throat:      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

A lump in the neck:        Yes: \_\_\_\_\_                      No: \_\_\_\_\_

Painful throat or neck:      Yes: \_\_\_\_\_                      No: \_\_\_\_\_

## HEAD & NECK SPECIALTY GROUP – OFFICE FINANCIAL POLICY

If you have medical insurance, we will be happy to bill most insurance companies if you provide our office with all the necessary information. Any balance, however, is ultimately your responsibility. Your co-payment or co-insurance is due at the time of your visit. If you have no insurance, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa and Discover.

### MEDICAL INSURANCES:

We participate with the following insurances: **Anthem BCBS/Matthew Thornton, Cigna HealthCare, EBPA, Heathcare Value Management, PHCS, Harvard Pilgrim, Martins Point. Tricare-(Standard only), Medicare, NH Medicaid.**

For other insurance companies that we do not participate with, we will make a reasonable effort to bill. However, there may not be any benefits or there may be limited benefits for services by our physicians. Please be advised that it is your (the patient's or insured's) responsibility to contact your insurance company to see what your plan covers prior to treatment. In cases of liability, we do not bill third party insurances or attorneys; payment in full is expected at the time of your visit.

If your insurance has not paid within 60 days, the balance will become your responsibility and we recommend that you contact your insurance company.

### MANAGED CARE INSURANCES:

As a specialty practice, our physicians are not authorized to provide services for patients with managed care insurance without authorization from their primary care physician. The exception to this would be if your insurance includes a Point of Service or Option 2 plan, which allows you to choose treatment without a referral. In this case, you need to notify our office that you have chosen this option (if applicable). For all other HMOs, please be advised that it is your (the patient's or insured's) responsibility to make certain a referral authorization has been received in our office prior to your appointment or bring your referral with you at time of appointment. If you do not have the referral with you or the referral is not in our office the day of your appointment, you will be responsible for any charges denied by your insurance for no referral.

### ADDITIONAL INFORMATION:

You will receive two separate bills for x-rays, one from Head & Neck Specialty Group for the technical component and one from Associates in Radiology for the reading of the x-ray.

If your insurance company requires that you provide them with a signed claim form or accident details, it is your responsibility to do so. Failure to respond to requests from your insurance company will result in the balance becoming your responsibility.

In cases of divorced or separated parents, our policy is that the parent bringing the child into our office for services must be responsible for any balance.

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I hereby authorize **Head & Neck Specialty Group** to furnish my health information for purposes relating to treatment, payment, and health care operations, and I hereby assign to **Head & Neck Specialty Group** all payments for medical services rendered. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered. I have read the information in this OFFICE FINANCIAL POLICY and verify that all insurance information is true and correct to the best of my knowledge.

I hereby agree to consultation with Head & Neck Specialty Group and agreed-upon treatment. I understand that this signature is valid for any treatment for the duration of one year.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

Parent Social Security Number (if patient is a minor): \_\_\_\_\_

# **HEAD & NECK SPECIALTY GROUP OF NH**

## **SUMMARY JOINT NOTICE OF HEALTH INFORMATION PRACTICES**

We are required by federal law to provide a Joint Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Joint Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws.

When this Summary Joint Notice refers to “we” or “us”, it is referring to Head & Neck Specialty Group.

### **USES AND DISCLOSURES**

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances, we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- to provide information about your health condition to others who may treat you;
- to provide information about the treatment that we provided in order to obtain payment from your health plan
- to report a communicable disease, domestic violence or criminal activity; or
- to comply with a court order requiring the disclosure of your medical record.

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, consult the Joint Notice of Privacy Practices.

### **YOUR RIGHTS**

While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Joint Notice.

### **OUR OBLIGATIONS**

We are required to provide you with our Joint Notice of Privacy Practices and to abide by its terms. We may amend the Joint Notice from time to time. All amendments apply retroactively. A copy of our full Joint Notice of Privacy Practices is available upon request. Please read it carefully. If you have any questions or require additional information, please contact:

Joyce M. O'Day RN, Office Manager  
361 High Street  
Somersworth, NH 03878  
603-692-4500

**ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES**

I have received a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Joint Notice may be changed at any time. I may obtain a revised copy of the Joint Notice by calling Laurie Seavey at 603-692-4500 or by requesting one at the office.

\_\_\_\_\_  
(Please Print your Full Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

As the representative of the above individual, I acknowledge receipt of the Joint Notice on his or her behalf.

\_\_\_\_\_  
(Please Print your Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)