PATIENT REGISTRATION FORM RONALD J ESCUDERO, MD, FACS

Please print clearly and fill out completely

Patient Legal Name _____ Birthdate _____ Age_____
Address _____ Social Security # _____
City _____ST_____ZIP_____ Email _____
Phone Numbers (____) _____ Home (____) _____ Cell (____) _____ Work
Gender: ☐Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employer _____ Occupation _____

Spouse's Name _____ Phone (_____) _____
Employer _____ Occupation _____

Primary Care Physician _____ Referred by _____

IF YOU ARE A MINOR *(under 18 years of age)*

Mother's Name _____ Birthdate _____ Age_____
Address _____ Social Security #_____
City_____ ST_____ZIP_____ Phone (_____)_____
Employer _____ Email_____

Father's Name _____ Birthdate _____ Age_____
Address _____ Social Security #_____
City_____ ST_____ZIP_____ Phone (_____)_____
Employer _____ Email_____

MEDICAL INSURANCE INFORMATION *Please Present Insurance Card at Each Office Visit*

Primary Insurance _____ Policy Holder Name _____
Relationship _____ Date of Birth _____ Employer _____
Address (if different than above) _____
Member ID # _____ Group # _____

Secondary Insurance _____ Policy Holder Name _____
Relationship _____ Date of Birth _____ Employer _____
Address (if different than above) _____
Member ID # _____ Group # _____

I hereby authorize Ronald J. Escudero, M.D. to furnish information concerning my illness and treatment to my Primary Care Physician or any Physician or Hospital that I may be referred to for additional diagnosis or treatment and to my insurance carrier or Medicare as necessary for processing claims. I assign Ronald J. Escudero, M.D. all payments for services rendered. I agree that in the event my insurance company denies payment, that I am ultimately responsible for any unpaid balance on my account. I understand the office will charge me $20.00 for filling out certain forms such as disability or other forms required by my employer. I also understand a $25.00 fee will be charged for checks returned for insufficient funds.

Signature _____ **Date** _____

Ronald J. Escudero, MD FACS

PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Date of Birth**: _____

Primary Care Physician: _____

Habits: Do you Smoke? ☐ NO ☐ YES If Yes, How many per day? _____

If Former Smoker, the date you quit: _____ Weight: _____ Height: _____

Drug Allergies:

List Previous Surgeries or Major Illnesses and Dates:

List any Medications you are taking, Including Non-Prescription Drugs, Vitamins and Herbals:

Please Circle YES or NO for the Following Questions Below:

FAMILY HISTORY *Has any Blood Relative ever had the Following*:

Breast Cancer	NO	YES	High Blood Pressure	NO	YES	Kidney Disease	NO	YES
Melanoma	NO	YES	Heart Disease	NO	YES	Depression	NO	YES
Stroke	NO	YES	Diabetes	NO	YES			

PAST MEDICAL HISTORY *Have You Ever Had the Following*:

Heart Disease	NO	YES	Cancer	NO	YES	Stomach Ulcer	NO	YES
Arthritis	NO	YES	Glaucoma	NO	YES	Kidney Disease	NO	YES
Rheumatic Fever	NO	YES	Asthma	NO	YES	Thyroid Disease	NO	YES
Anemia	NO	YES	AIDS or HIV +	NO	YES	Bleeding Tendency	NO	YES
Tuberculosis	NO	YES	Stroke	NO	YES	Mitral Valve Prolapse	NO	YES
Diabetes	NO	YES	Hepatitis	NO	YES	High Blood Pressure	NO	YES

REVIEW OF SYSTEMS *Do you Now Have or Have You Had Within the Past Year:*

Dry Eyes	NO	YES	Depression	NO	YES	Swollen Feet	NO	YES
Skin Rash	NO	YES	Chronic Cough	NO	YES	Weight Change	NO	YES
Easy Bleeding	NO	YES	Chest Pain	NO	YES	Swollen Lymph Nodes	NO	YES
Chronic Diarrhea	NO	YES	Jaundice	NO	YES	Joint/Muscle Pain	NO	YES
Seizures	NO	YES						

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OR PATIENT OR PARENT IF MINOR DATE

FOR PHYSICIAN USE ONLY:
HISTORY OF PRESENT ILLNESS

Ronald J. Escudero, M.D. F.A.C.S.

Consent For Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Dr. Ronald Escudero for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Escudero. I understand that diagnosis or treatment of me by Dr. Escudero may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Escudero is not required to agree to the restrictions that I may request. However, if Dr. Escudero agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Escudero has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. Escudero's Notice of Privacy Practices prior to signing this document. Dr. Escudero's Notice of Privacy Practices **is posted and will be made available to me upon my request**. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Escudero. This Notice of Privacy Practices also describes my rights and the duties and Dr. Escudero's duties with respect to my protected health information.

Dr. Escudero reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Please Print Name of Patient

Ronald J. Escudero, MD, FACS, PC

FINANCIAL AND PAYMENT POLICY

INSURANCE- If you have medical insurance in which our office is a contracted provider, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with a copy of your insurance card. We are required to file your claim with your current name and demographic information, as well as to have a timely signature for permission to release information to your insurance carrier.

We will file claims for your covered medical services to your insurance company. It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals and authorization requirements. We will, however, assist you to insure all plan requirements are met.

SERVICES YOU MIGHT RECEIVE- Your office visit with Dr. Escudero may very likely also include diagnostic/therapeutic procedures that will assist the doctor in his evaluation of your condition. Most common of these is endoscopy, a tool that allows visualization of your nasal anatomy; laryngoscopy, a tool that allows visualization of your throat anatomy; nasal cautery for treatment of nosebleeds; tympanometry, to evaluate ear drum activity; ear wax removal; etc. These procedures are a routine part of the doctor's examination process and do not require written consent prior to being performed. Please be aware that your insurance company will process these procedures as a separate charge, and, most often, at a benefit level beyond any copay you have for the office visit. If you do not wish to have any of these procedures performed as part of your visit because of questions about cost, please notify our staff prior to seeing Dr. Escudero.

PAYMENT FOR SERVICES- Payment for services, including co-payment and deductible amounts, is due at the time services are rendered. We accept cash, checks, MasterCard, VISA, Discover and American Express. Returned checks, balances over 60 days, and failure to pay account balances as promised may be subject to external collection and additional fees.

CANCELLED APPOINTMENTS- Charges may be made for broken, confirmed appointments and appointments cancelled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment time allows us the opportunity to offer your appointment to another person who needs medical care.

GENERAL- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand, however, that: We participate in many of the local insurance plans. Your insurance, however, is a contract between you and the insurance company. We are, often, not a party to that contract. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us.

Thank you.

My signature below constitutes acknowledgement and acceptance of this policy.

_____ _____

Patient or Guarantor Date

Ronald J. Escudero, MD FACS

MEANINGFUL USE PATIENT REGISTRATION FORM

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name: _____ **DOB:** _____ **Age:** _____

Race:

_____ **African-American**
_____ Arabic
_____ Asian
_____ Caucasian
_____ Filipino
_____ Hispanic
_____ Other: _____

Ethnicity:

_____ Hispanic
_____ Non-Hispanic

Primary Language:

_____ Arabic
_____ Chinese
_____ English
_____ French
_____ Korean
_____ Spanish
_____ Other: _____

Please provide information about previous tests, immunization (including date or year of the last).

Flu Shot _____ Pneumococcal Vaccine _____

Male:
Colonoscopy _____

Female:
Colonoscopy _____
Mammogram _____

Tobacco Use:

_____ Never
_____ Current Every Day Smoker
_____ Current Smoker – Does Not Smoke Every Day
_____ Former Smoker: Date Quit: _____
_____ Exposure to Environmental Tobacco Smoke
_____ Occupational Exposure to Environmental Tobacco Smoke
_____ Exposure to Tobacco Smoke in the Perinatal Period

_____ _____

Patient or Guardian Signature **Date**