Sinus Relief Center

(PLEASE PRINT CLEAR AND COMPLETE ALL FIELDS APPLICABLE)

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: Male / Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Social Security #: _____ Email: _____

Employer: _____ Employer Phone:_____ Position: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referred by ☐ Physician: _____ ☐ Friend: _____

☐ Social Media: _____ ☐ Billboard ☐ Google ☐ YouTube ☐ Instagram

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Name: _____ Member ID #:_____ Group #_____

Name of Insured: _____Date of Birth: _____Social Security #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Member ID #:_____ Group #_____

Name of Insured: _____Date of Birth: _____Social Security #: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENTS

***PLEASE READ AND INITIAL BELOW**

_____**I hereby authorize Dr. Vincent Nalbone / Sinus Relief Center to conduct Telemedicine video calls.**

_____**I hereby authorize medical treatment and fully acknowledge that all office visits will be paid in full at the time of visit, unless otherwise contracted by my insurance. I understand that my insurance policy is a contract between my insurance company and myself. I further understand that I am responsible for any fees not covered by my insurance.**

_____**I understand that co-payments and deductibles are due at the time of service. I understand that I will be charged $25 for an unexcused no-show or cancellation within 24 hours of my appointment time. If FMLA or Disability paperwork is required for my condition, I am aware there will be a fee of $35. I hereby acknowledge that I am able to request a copy of the Notice of Privacy Practices (HIPAA).**

_____**I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document attached. I understand that I am able to request a copy of the HIPAA Notice of Privacy Practices.**

_____**In the event of default on any payments due to Dr. Vincent Nalbone, MD, I agree to pay the full costs of collection, including attorney fees. I hereby authorize the filing of any insurance in force and the direct payment to Dr. Vincent Nalbone, MD of any amounts due on my claim. I further authorize the office of Dr. Vincent Nalbone, MD to release any and all pertinent medical records necessary to facilitate insurance billing or medical care; and authorize the creditor or higher agent to make any insurance verification and release of all information needed to process claims. I hereby authorize the office of Dr. Vincent Nalbone, MD to receive, mail, fax, or email my medical records to another physician or medical facility in the course of my diagnosis and treatments.**

I hereby authorize Dr. Vincent Nalbone, MD to discuss my medical care in detail with (LIST NAMES):

_____

Patient / Guardian / Parent Printed Name: _____

Patient / Guardian / Parent Signature: _____ **Date:** _____

MEDICAL HISTORY

Patient Name: _____ **Height:** _____ **Weight:** _____

Please list any medications you are currently taking below (include vitamins & supplements):

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you allergic to any medications? ☐ **No** ☐ **Yes, List**:_____

_____

Pharmacy Name:_____ **Pharmacy Address**: _____

PERSONAL HISTORY

Have you ever had surgery? ☐ **No** ☐ **Yes, List:** _____
Hospitalizations? ☐ **No** ☐ **Yes, List:** _____
Any medical problems that run in the family? ☐ **No** ☐ **Yes, List:** _____
Do you Smoke or chew tobacco? ☐ **Yes** ☐ **No** **Drink alcohol?** ☐ **Yes** ☐ **No** **Use other drugs?** ☐ **Yes** ☐ **No**
Are you? ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other**: _____
Lives in: ☐ **House** ☐ **Apartment** ☐ **Condo** ☐ **Other**: _____
Are you Claustrophobic? ☐ **Yes** ☐ **No** **Do you have any metal in the body?** ☐ **Yes** ☐ **No**
Have you traveled out of the country recently? ☐ **Yes** ☐ **No**

(Please circle if you have had or currently have any of the following problems)

Constitutional: fevers / sweats / weight loss / change in appetite
Eyes: new vision problems / double vision / cataracts
ENT: ear / nose / throat
Hematologic/ Lymphatic: bleeding disorders / easy bruising
Cardiovascular: murmur / heart disease / heart attack / chest pain
Respiratory: cough, asthma / tuberculosis / shortness of breath / wheezing
Gastrointestinal: nausea / vomiting / diarrhea / abdominal pain / acid reflux / indigestion
Genitourinary: infections / difficulty urinating / frequent urination
Psychiatric: ADHD /anxiety / depression / drug dependence
Endocrine: diabetes / thyroid problems
Allergic/ Immunologic: immune problems / food allergy / environmental allergy / eczema / HIV
Skin Problem: skin infection / rashes / skin changes / skin cancer
Musculoskeletal: arthritis / joint pain / mobility problems
Neurological: seizures / headaches / vertigo / weakness / stroke / developmental delay

Patient / Guardian / Parent Printed Name: _____

Patient / Guardian / Parent Signature: _____ Date: _____

Vincent Nalbone, M.D.
9111 W. Russell Rd., Ste. A, Las Vegas, NV 89148 | Phone: (702)312-3333 | Fax: (702)312-1144

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Patient Name: _____
Date: _____

Please check off whatever meds you have used in the past:

Antihistamines:

☐ Claritin (loratidine) ☐ Allegra (Fexofenadine) ☐ Zyrtec (cet irizine)
☐ Benadryl ☐ Clemastine (Tavist) ☐ Chlorpheniriamine (Chlor-Trimeton)
☐ Clarinex ☐ Seldane ☐ Brompheniriamine (Dimetane)
☐ Seldane ☐ Xyzal
☐ _____ ☐ _____ ☐ _____

Decongestants

☐ Sudafed ☐ Afrin ☐ Neosynephrine ☐ 4-Way nasal spray
☐ _____ ☐ _____ ☐ _____ ☐ _____

Rinses

☐ Saline spray ☐ Neti Pot ☐ Neil-Med Spray ☐ Ocean Spray
☐ Navage ☐ Water-Pik
☐ _____ ☐ _____ ☐ _____ ☐ _____

Nasal Sprays

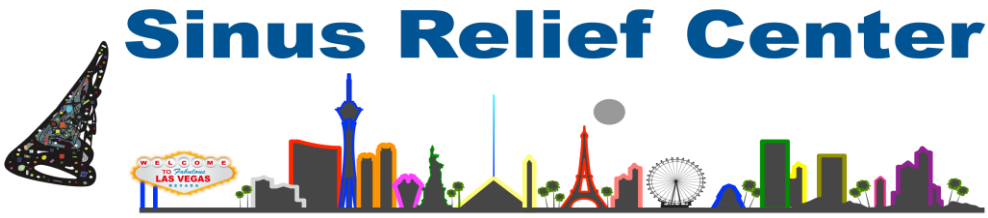
☐ Flonase ☐ (Fluticasone) ☐ Nasacort ☐ Rhinocort
☐ Dymista ☐ Budesonide ☐ Veramyst ☐ Nasonex
☐ Astelin ☐ Beconase ☐ Vancenase ☐ Atrovent
☐ Azelastine ☐ Qnasal ☐ Nasarel ☐ Zetonna
☐ Nasalide ☐ Tri-Nasal ☐ Omnaris
☐ _____ ☐ _____ ☐ _____ ☐ _____

Antibiotics

☐ Penicillin ☐ Amoxicillin ☐ Augmentin ☐ Zpack
☐ Omnicef (Cefdinir) ☐ Bactrim ☐ Doxycycline ☐ Clindamycin
☐ Cipro ☐ Levaquin ☐ Biaxin ☐
☐ _____ ☐ _____ ☐ _____ ☐ _____

Other

☐ Steroids ☐ Mucinex ☐ Robitussin
☐ _____ ☐ _____ ☐ _____ ☐ _____



Vincent Nalbone, M.D.
Ear, Nose, and Throat
Facial Plastic and Reconstructive Surgery

CONSENT TO RECEIVE APPOINTMENT REMINDERS

By signing below, I authorize Sinus Relief Center/Vegas ENT/Vincent Nalbone, MD, to send appointment reminders through my email address, SMS mobile text, and voice messaging calls through our third party company Updox.

_____ (*Patient initials*) I consent to emails, to receive communications as stated above.

The **email** that I authorize to receive email messages for appointment reminders is:
_____

_____ (*Patient initials*) I consent to receive text messages, to receive communications as stated above.

The **mobile number** that I authorize to receive text messages for appointment reminders is:

(_____) _____ - _____

_____ (*Patient initials*) I consent to receive voice messaging calls, to receive communications as stated above.

The **phone number** that I authorize to receive voice messaging calls for appointment reminders is:

(_____) _____ - _____

MY PREFERRED METHOD TO RECEIVE APPOINTMENT REMINDERS IS THROUGH

☐ Email Reminders ☐ Text Messaging Reminders ☐ Voice Messaging Calls

I understand that this request to receive emails, text messages and/or voice messaging calls will apply to all future appointment reminders unless I request a change in writing.

_____ _____
PATIENT NAME **DATE OF BIRTH**

_____ _____
PATIENT SIGNATURE **DATE**

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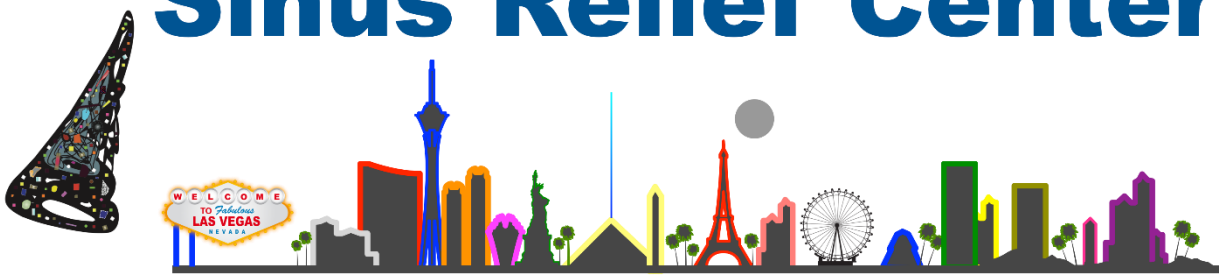

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced ovr the past two weeks.

Patient Name: _____

Sino-Nasal Outcome Test (SNOT-22)

Patient Phone: _____ **Date:** _____

1. Consider how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale. 2. Please mark the most important items affecting your health (maximum of 5 items), right column.	No Problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bas it can be	TOTAL	5 Most Important Problems
1. Need to blow nose	0	1	2	3	4	5		O
2. Nasal blockage / Congestion	0	1	2	3	4	5		O
3. Sneezing / Allergies	0	1	2	3	4	5		O
4. Runny nose	0	1	2	3	4	5		O
5. Cough	0	1	2	3	4	5		O
6. Post-nasal drip, constantly clearing throat	0	1	2	3	4	5		O
7. Thick Nasal discharge	0	1	2	3	4	5		O
8. Ear fullness	0	1	2	3	4	5		O
9. Dizziness	0	1	2	3	4	5		O
10. Ear pain	0	1	2	3	4	5		O
11. Facial pain/pressure	0	1	2	3	4	5		O
12. Decreased sense of smell/taste	0	1	2	3	4	5		O
13. Difficulty falling asleep	0	1	2	3	4	5		O
14. Wake up at night coughing/choking	0	1	2	3	4	5		O
15. Lack of good night's sleep	0	1	2	3	4	5		O
16. Wake up tired	0	1	2	3	4	5		O
17. Fatigue	0	1	2	3	4	5		O
18. Reduced productivity	0	1	2	3	4	5		O
19. Reduced concentration	0	1	2	3	4	5		O
20. Frustrated/restless/irritable	0	1	2	3	4	5		O
21. Sad	0	1	2	3	4	5		O
22. Embarrassed	0	1	2	3	4	5		O
						TOTAL:		

Have you had allergy testing done before? Yes No

If yes, what were the results? _____

_____