



(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: _____

Facebook Instagram TV Ad Radio Google YouTube Valpak Yelp

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 Nalbhone, M.D.

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Patient Name: _____

Date: _____

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

Antihistamines:

- | | | |
|--|---|--|
| <input type="checkbox"/> Claritin (loratidine) | <input type="checkbox"/> Allegra (Fexofenadine) | <input type="checkbox"/> Zyrtec (cet irizine) |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Clemastine (Tavist) | <input type="checkbox"/> Chlorpheniramine (Chlor-Trimeton) |
| <input type="checkbox"/> Clarinex | <input type="checkbox"/> Seldane | <input type="checkbox"/> Brompheniramine (Dimetane) |
| <input type="checkbox"/> Seldane | <input type="checkbox"/> Xyzal | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Decongestants

- | | | | |
|----------------------------------|--------------------------------|--|--|
| <input type="checkbox"/> Sudafed | <input type="checkbox"/> Afrin | <input type="checkbox"/> Neosynephrine | <input type="checkbox"/> 4-Way nasal spray |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Rinses

- | | | | |
|---------------------------------------|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Saline spray | <input type="checkbox"/> Neti Pot | <input type="checkbox"/> Neil-Med Spray | <input type="checkbox"/> Ocean Spray |
| <input type="checkbox"/> Navage | <input type="checkbox"/> Water-Pik | | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Nasal Sprays

- | | | | |
|-------------------------------------|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> Flonase | <input type="checkbox"/> (Fluticasone) | <input type="checkbox"/> Nasacort | <input type="checkbox"/> Rhinocort |
| <input type="checkbox"/> Dymista | <input type="checkbox"/> Budesonide | <input type="checkbox"/> Veramyst | <input type="checkbox"/> Nasonex |
| <input type="checkbox"/> Astelin | <input type="checkbox"/> Beconase | <input type="checkbox"/> Vancenase | <input type="checkbox"/> Atrovent |
| <input type="checkbox"/> Azelastine | <input type="checkbox"/> Qnasal | <input type="checkbox"/> Nasarel | <input type="checkbox"/> Zetonna |
| <input type="checkbox"/> Nasalide | <input type="checkbox"/> Tri-Nasal | <input type="checkbox"/> Omnaris | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Antibiotics

- | | | | |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Augmentin | <input type="checkbox"/> Zpack |
| <input type="checkbox"/> Omnicef (Cefdinir) | <input type="checkbox"/> Bactrim | <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Clindamycin |
| <input type="checkbox"/> Cipro | <input type="checkbox"/> Levaquin | <input type="checkbox"/> Biaxin | <input type="checkbox"/> |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Other

- | | | | |
|-----------------------------------|----------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Mucinex | <input type="checkbox"/> Robitussin | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |



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

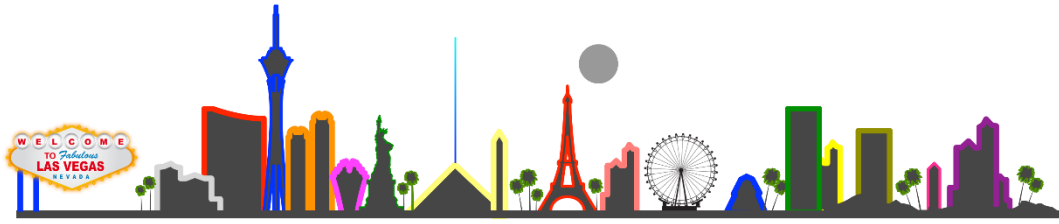
DATE OF BIRTH

PATIENT SIGNATURE

DATE



Sinus Relief Center



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 over the past two weeks.

Sino-Nasal Outcome Test (SNOT-22)

Patient Name: _____

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 bad as it can be	TOTAL	5 Most Important Problems
1. Need to blow nose	0	1	2	3	4	5		<input type="radio"/>
2. Nasal blockage / Congestion	0	1	2	3	4	5		<input type="radio"/>
3. Sneezing / Allergies	0	1	2	3	4	5		<input type="radio"/>
4. Runny nose	0	1	2	3	4	5		<input type="radio"/>
5. Cough	0	1	2	3	4	5		<input type="radio"/>
6. Post-nasal drip, constantly clearing throat	0	1	2	3	4	5		<input type="radio"/>
7. Thick Nasal discharge	0	1	2	3	4	5		<input type="radio"/>
8. Ear fullness	0	1	2	3	4	5		<input type="radio"/>
9. Dizziness	0	1	2	3	4	5		<input type="radio"/>
10. Ear pain	0	1	2	3	4	5		<input type="radio"/>
11. Facial pain/pressure	0	1	2	3	4	5		<input type="radio"/>
12. Decreased sense of smell/taste	0	1	2	3	4	5		<input type="radio"/>
13. Difficulty falling asleep	0	1	2	3	4	5		<input type="radio"/>
14. Wake up at night coughing/choking	0	1	2	3	4	5		<input type="radio"/>
15. Lack of good night's sleep	0	1	2	3	4	5		<input type="radio"/>
16. Wake up tired	0	1	2	3	4	5		<input type="radio"/>
17. Fatigue	0	1	2	3	4	5		<input type="radio"/>
18. Reduced productivity	0	1	2	3	4	5		<input type="radio"/>
19. Reduced concentration	0	1	2	3	4	5		<input type="radio"/>
20. Frustrated/restless/irritable	0	1	2	3	4	5		<input type="radio"/>
21. Sad	0	1	2	3	4	5		<input type="radio"/>
22. Embarrassed	0	1	2	3	4	5		<input type="radio"/>

TOTAL:

Have you had allergy testing done before? Yes No

If yes, what were the results?
