David Greene, MD, LLC
1112 Goodlette Frank Rd. North, Suite 203
Naples, FL 34102

Patient Registration Form

Patient Information

Patient Information			
First Name:	Last Name:	MI:	
Sex: [ ] Male [ ] Female [ ] Other	Date of Birth:	Social Security #:	
Cell Phone:	Email:	Home Phone:	
Home Address:		Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: [ ] Text [ ] Email [ ] Voice IF Voice, Please select Preferred Number: [ ] Home [ ] Cell [ ] Work			
Primary Care Provider:	PCP Phone: Fax:		
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other:			
Emergency Contact:	Relationship to Patient:	Emergency Contact #:	
Out-of-Town Address:		Phone (up north/ out-of-town):	

Additional Information and Responsible Party

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian bringing the patient it will be listed as the guarantor:		
Last Name:	First Names:	
Date of Birth:	Social Security #:	Phone Number:
Address of Responsible Party:		
City/ State/ Zip:		Relationship to Pt:
Preferred Pharmacy Name and Location:		
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:
Demographics: Preferred Language [ ] English [ ] Spanish [ ] Sign Language [ ] Other: Ethnicity/ Race: [ ] Hispanic or Latino [ ] White [ ] Black or African American [ ] Asian [ ] Decline [ ] American Indian or Alaska Native [ ] Native Hawaiian or Pacific Islander [ ] Other		

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Company Name:	Ins. Company Name:
Policy Holder's Names:	Policy Holder's Names:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Number:	Policy ID Number:
Patient Relationship to Policyholder:	Patient Relationship to Policyholder:

I certify that I have read and agree to DAVID GREENE MD, LLC (DGMDLLC) payment policy. I am eligible for the insurance indicated on this form and I understand that my payment is my responsibility regardless of insurance coverage. I hear by assign to DGMDLLC all money to which I am entitled for medical expenses related to the services performed from time to time by DGMDLLC, but not to exceed my indebtedness to DGMDLLC. I authorize DGMDLLC to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 return check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from DGMDLLC by text or email at the number or address stated above, included but not limited to communications about appointments, feedback, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third-party. Comments submitted on surveys may be anonymously shared by DGMDLLC Public Website. I certified that I have read and received the Notice of Private Practices.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to DGMDLLC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits of the benefits payable for related services.

Signature of Responsible Party:_____ **Date:**_____

Printed Name of Responsible Party:_____**Date:**_____

ENT NEW PATIENT MEDICAL HISTORY FORM
David Greene, MD, FACS, FARS
Board Certified, Otolaryngology
Nasal, Sinus & Facial Plastic Surgery

Name _____

Date _____

Date of Birth_____

Referring Provider _____

CHIEF COMPLAINT / REASON FOR VISIT

_____
_____
_____
_____
_____

ALLERGIES TO MEDICATION YES NO

(Please list the medication and with reaction you have to the allergy. EX: Rash, Hives, Swelling, Anaphylaxis.)

_____
_____
_____

MEDICATIONS *Please list all medications you are taking including vitamins, supplements, & over the counter meds*

_____
_____
_____

REVIEW OF SYSTEMS *Do you currently or frequently have any of these symptoms? (circle answers)*

Constitutional			
Fatigue	No	Yes	
Fever	No	Yes	
Weight loss	No	Yes	
Weight gain	No	Yes	
Ears			
Hearing loss	No	Yes	R L
Ear pain	No	Yes	R L
Ear drainage	No	Yes	R L
Ringing in Ears	No	Yes	R L
Dizziness	No	Yes	
Nose			
Nasal congestion	No	Yes	
Post nasal drainage	No	Yes	
Sinus infections	No	Yes	
Runny nose	No	Yes	
Nose bleeding	No	Yes	R L
Congestion	No	Yes	
Decreased smell	No	Yes	
Sinus pain	No	Yes	
Throat/ Mouth			
Change in voice	No	Yes	
Trouble swallowing	No	Yes	
Sore throat	No	Yes	
Snoring	No	Yes	
Phlegm	No	Yes	
Excess throat mucus	No	Yes	
Oral sores/ growths	No	Yes	

Neck/ Lymphatic/ Endocrine		
Neck lump/ mass	No	Yes
Swollen glands	No	Yes
Thyroid problems	No	Yes
Lungs		
Short of breath	No	Yes
Wheezing	No	Yes
Cough	No	Yes
Heart		
Chest pain	No	Yes
Gastrointestinal		
Heartburn	No	Yes
Indigestion	No	Yes
Neurological/ Psych		
Headaches	No	Yes
History of falls	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Skin		
Rash	No	Yes
Skin cancer	No	Yes
Musculoskeletal		
Arthritis	No	Yes

Blood

Bleeding/ Bruising	No	Yes
Blood thinners	No	Yes
Aspirin	No	Yes
Ibuprofen etc.	No	Yes

Allergy/ Immune

Seasonal allergies	No	Yes
Food allergies	No	Yes
Latex allergy	No	Yes
Frequent infections	No	Yes

SOCIAL HISTORY

Tobacco

Smoking-ever	No	Yes
Smoking-current	No	Yes
1 pack/day (less than 20)	No	Yes
2 packs/day (up to 40)	No	Yes
Chewing tobacco	No	Yes

Alcohol

Alcohol-ever	No	Yes
Alcohol-current	No	Yes
Over 3 drinks daily	No	Yes

Other

Caffeine	No	Yes	___ / day
Vaping	No	Yes	
Recreational drugs	No	Yes	_____ type

VACCINATIONS

Pneumonia shot	No	Yes	___ / ___ / ____
Influenza shot	No	Yes	___ / ___ / ____
COVID shot	No	Yes	___ / ___ / ____

CURRENT HEIGHT/ WEIGHT

Height: ____ ft ____ in Weight: _____ lbs

PAST MEDICAL HISTORY *(circle all that apply - please add any additional medical history)*

Anesthesia Complications	No	Yes	GERD/ Reflux	No	Yes
High blood pressure	No	Yes	Sleep apnea	No	Yes
Diabetes	No	Yes	Thyroid disease	No	Yes
Autoimmune disorder	No	Yes	Heart disease	No	Yes
Stroke/ TIA	No	Yes	Lung disease	No	Yes
COPD/ Emphysema	No	Yes	MRSA* skin infection	No	Ye
Bleeding disorder	No	Yes	Hepatitis	No	Yes
Skin cancer	No	Yes	Head or Neck cancer	No	Yes
Cancer	No	Yes	Other chronic illness	No	Yes
AIDS or HIV	No	Yes			

Other: _____

PAST SURGICAL HISTORY *(circle all that apply - please add any additional surgical history)*

Septoplasty Nasal Fracture Rhinoplasty Sinus surgery Turbinate surgery Dental implants
Tonsillectomy Adenoidectomy Ear tubes Ear surgery (other than tubes) Esophagus surgery
Other: _____

HOSPITALIZATIONS No Yes Describe _____
ACCIDENTS No Yes Describe _____

FAMILY HISTORY

High blood pressure Diabetes Hearing loss Sleep apnea Heart attack Stroke

Diseases in Father: _____
Diseases in Mother: _____

** Any problems with excessive bleeding or anesthesia related problems in your family members?*
No Yes Describe _____

Other information not listed above: _____
_____
_____
_____

The above knowledge is completed to the best of my knowledge.

Name (printed): _____Signature: _____ Date: _____

Authorization and Assignment of Benefits

I authorize DAVID GREENE, MD, LLC to release any information to my insurance company. I authorize direct payment of medical/ surgical benefits to DAVID GREENE, MD, LLC. I understand that I am financially responsible to the Provider for all charges, for any balance or fee not covered in the event that I have no insurance, or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

Private Insurance Authorization for Assignment of Benefits/ Information Release - I, the undersigned, authorize the payment of medical benefits to DAVID GREENE, MD, LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contact. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to DAVID GREENE, MD, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

I declare that all information presented at the date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.
I have read and fully understand this information and I agreed to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to the account.

I consent to retrieve my prescription history into my medical record and the electronic medical record system of this practice.

I consent to this medical record being allowed to interface with the humanization registry.

I acknowledge this practice may use offsite scribes to type in counter notes and perform data entry into the electronic medical record.

I hereby assign and transfer any insurance benefit to me for the professional services that I have received to DAVID GREENE, MD, LLC. My practice has documented that this patient has provided their prior expressed consent to receive automated text and voice messages at the phone number(s) above.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, included but not limited to home phone, work phone, cell phone, text an email, or any other phone numbers in compliance with the Telephone Consumer Protection Act (TCPA).

I have read and understand the practice's financial and administrative policies and I agree to be bound by its items. I also understand and agree that such terms may be amended by the practice from time to time

Patient Name (Printed) _____

Patient Signature _____

Date_____

Responsible Party Name_____ Responsible Party Signature_____

Relationship _____ Date _____

ACKNOWLEDGEMENT OF MEDICALLY NECESSARY PROCEDURES THAT YOUR INSURANCE MAY APPLY TO YOUR DEDUCTIBLE

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your physician may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. **As per the rules of your insurance carrier, you will be responsible for covering any deductible payment.**

DAVID GREENE, MD, LLC and the Florida Sinus Institute follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, Cerumen (Wax) Removal, Ear Microscopy, and Sinus Debridement.

I acknowledge that I have read and understand the above disclosure.

Name _____

Signature _____

Date _____

David Greene, MD, FACS
Otolaryngology, Nasal & Facial Plastic Surgery
Florida Sinus Institute
1112 Goodlette Road N. #203
Naples, FL 34102

Patient Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____Cell #: _____Other: _____

I authorize _____ to release healthcare Information to:
Facility/ Company: David Greene, MD, FACS
Address: 1112 Goodlette Frank Rd. North Suite 203 City: Naples State: FL Zip: 34102
Phone Number: (239) 263 - 8444 Fax Number: (239) 308 - 0894 .

I authorize the release/ disclosure of the following healthcare information:

[X] Visit Note(s)	[X] ED Records	[X] Diagnostic Imaging Report(s)	[X] Laboratory Reports
[X] Pertinent Records	[X] Immunization Record(s)	[ ] Diagnostic Imaging Film(s)	[ ] Billing Record(s)
[X] Plan of Care	[X] Medication Record(s)	Other (describe) _____	

Dates of Information to be disclosed: from _____to _____
Purpose of disclosure: [ ] Insurance [ ] Legal [X] Physician [ ] Self [ ] Research [ ] AFH/ALF [ ] Other _____
Is disclosure to an employer or financial institution? [ ] Yes [ ] No (if yes, authorization expires 1 year after signing)

This authorization may include the release of the following sensitive medical information unless specifically excluded (please check if you do NOT want this information released):
[ ] Sexually Transmitted Disease [ ] AIDS/HIV Diagnosis Reports(s) [ ] Alcohol/ Drug Abuse or Treatment [ ] Mental Health

DAVID GREENE MD LLC is hereby released for all legal responsibilities or liability for the release of the above-mentioned information.

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by Federal Confidential Rules that prohibit the recipient from making any further disclosure of this information unless further disclosed is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to DAVID GREENE MD LLC at the address listed above. I understand that I do not have to sign as authorization in order to receive Health Care treatment. I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a change.
This authorization expires on _____ or when the following event occurs _____ if there is no expiration date given, this authorization will expire one year from the date of signature. if the disclosure is to an employer or financial institution this authorization expires one year after signing.

Signature: _____ Date: _____
(if signed by a personal representative of the patient, please complete the following)
Personal Representative's Name: _____
Relationship to Patient: [ ] Parent [ ] Legal Guardian* [ ] Holder of a Power of Attorney* [ ] Executor of Estate*
*Please attach Legal Documentation if you are the Legal Guardian, Power of Attorney, or Executor of Estate
PLEASE PROVIDE A COPY OF GOVERNMENT ISSUED PHOTO ID

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION
FORM ID ADM 536
Approved 06/2020

APPLY PATIENT LABEL HERE

Authorization to Leave Patient Messages

The HIPAA Privacy Rule permits healthcare providers to communicate with patients regarding their healthcare. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individuals privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment and ask the individual to call back later.

A covered entity also may leave a message with a family member or other person who answers the phone when a patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PH I require the patient to sign an authorization form to receive messages by phone, fax, email, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPAA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment, or payment related.

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI may be provided to the designated relative or friend, sent by email, fax, or left on your voicemail at the number you provide to this office.

(This form is optional. We make follow-up appointments for all patients to discuss their test results with the Doctor, and you have the option of waiting until your visit for this information).

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below or by email, fax, or voicemail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

_____ _____

Patient Name Date

_____ _____

Relative/ Friend #1 Phone

_____ _____

Relative/ Friend #2 Phone

Patient's Contact Information

Fax # _____ Phone _____

Patient Email _____