

Appointment Information				
Doctor's Name: LABRUNA MD, ANTHONY	Provider # 6041	Appt Date:	Appt Time:	Appt #

## REGISTRATION FORM

Instructions: Fill in the blanks. Replace any wrong or outdated information by crossing it out and noting the change.

Patient Information								
First Name, MI		Last Name		Sex	Marital	DOB	Age	SSN
Address		City	State	Zip	NYH Chart #	IDX MRN		
Home Phone	Fax#	Cell Phone		Email Address		Patient's Birthplace		
Mother's Name		Mother's DOB (Peds Pts Only)		Mother's Home Phone		Mother's Work Phone		
Father's Name		Father's DOB (Peds Pts Only)		Father's Home Phone		Father's Work Phone		
Employer Name (Primary Policy Holder)				Employer Address				
City	State	Zip	Work Phone #		Work Fax #			
PERSON TO CONTACT IN CASE OF AN EMERGENCY								
Emergency Contact's Name			Relationship		Home Phone		Work Phone	

Your Physicians					
<i>Referring Physician's Name</i>					
Address		City	State	Zip	Phone
<i>Primary Care Physician Name</i>					
Address		City	State	Zip	Phone
<i>OB/GYN Name (female patients)</i>					
Address		City	State	Zip	Phone

Your Insurance Information					
PRIMARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date
SECONDARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date

### ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Weill Cornell Physicians, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Weill Cornell Physicians sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

{ } (Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

\_\_\_\_\_  
Signature of Patient or Authorized Guardian

\_\_\_\_\_  
Date

# Anthony LaBruna, MD

Date of visit: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Allergies to Medicines: 1. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ 2. \_\_\_\_\_

Primary Doctor: (Name/Address): \_\_\_\_\_ Current Medicines/ Doses: 1. \_\_\_\_\_

\_\_\_\_\_ 2. \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ 3. \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of spouse/Significant other: \_\_\_\_\_ 4. \_\_\_\_\_

Children's (Names/Birthdates): \_\_\_\_\_ 5. \_\_\_\_\_

Please List all prior major illnesses/surgeries (with years):

Operations: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Hospitalizations: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Illnesses/Injuries: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Family History (check)?  Heart disease  Diabetes  Cancer  Other \_\_\_\_\_

Which family member?: \_\_\_\_\_

Do you drink alcohol?  No, never  No, but I used to  Yes How many drinks? \_\_\_ day/week

Do you smoke?  No, never  No, I quit in \_\_\_\_\_  Yes Packs per day? \_\_\_\_\_ x \_\_\_\_\_ years.

Do you use illicit drugs?  No, never  No, but I used to  Yes Which drug? \_\_\_\_\_

Have you experienced any of the following? (Circle Y or N or N/A)

## Constitutional

weight gain/loss (>15lbs) Y N

constant night sweats Y N

## Eyes

double vision Y N

glaucoma Y N

## Ear/Nose/throat

hearing loss Y N

ear pain Y N

ringing in ears Y N

balance problems Y N

hearing aid Y N

difficulty breathing Y N

nosebleeds Y N

nasal drainage Y N

sinus problems Y N

snoring Y N

voice changes Y N

## Cardiovascular

heart attack Y N

↑ blood pressure Y N

heart murmur Y N

## Gastrointestinal

chronic diarrhea Y N

heartburn Y N

## Endocrine

diabetes Y N

thyroid disease Y N

autoimmune disease Y N

## Neurologic

headaches Y N

seizures Y N

stroke Y N

## Hematology

bruise easily Y N

anemia Y N

## Genitourinary

frequent urination Y N

prostate problems N/A Y N

## Skin

past skin cancer Y N

past radiation therapy Y N

## Musculoskeletal

arthritis

chronic back pain Y N

## Respiratory

asthma/emphysema Y N

chronic cough Y N

tuberculosis Y N

## Psychiatric

anxiety Y N

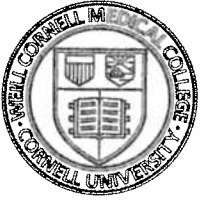
depression Y N

sleep apnea Y N

If you answered YES to any of the above, please explain: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

*Anthony LaBruna, MD*



**Weill Cornell Medical College**

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Weill Cornell Medical Center**

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**Financial Policy**

*Welcome to the Department of Otorhinolaryngology. The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.*

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have questions or concerns please call the office of the physician you are seeing.

**Participating Plans**

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments as outlined by your plan coverage. The co-payment is typically listed on your 98insurance card. The Medical College will then forward a bill to your insurance carrier who will inform the College if any deductible or percentage of payment is due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you will be responsible for full payment at the time of service.

**Non-Participating Plans**

In this scenario the physician you will see does not participate in your insurance plan. Payment for services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

**Medicare**

Drs. Kacker, Kuhel, Kutler, LaBruna, Modi, Pearlman, Prasad, Reisacher, Roure, Selesnick, Stewart, Sulica, and Voigt accept Medicare assignment, as do our Audiologists, Joseph Montano, Jennifer Aboud, Elaine Henry, Marjorie Klaskin, Michelle Kraskin and Hannah Shonfield. For their services, Medicare will be billed directly. Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance.

Some of the ENT physicians and Audiologists in the practice do not accept Medicare assignment. If the provider is not listed above you will be responsible for payment at the time of service. Your claim will then be forwarded to Medicare and reimbursed directly to you.

**Payment**

Cash, Check, Mastercard, Visa, Discover, American Express and NYCE cards are recognized forms of payment.

*We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office.*

X \_\_\_\_\_  
**Signature of the patient or responsible Party**

X \_\_\_\_\_  
**Date**