

WEILL CORNELL PHYSICIANS

| 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 Replace any wrong or outdated information by crossing it out and noting the change.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 | | | | |
|--------------------------------------|--|------|-------|-------|
| Referring Physician's Name | | | | |
| Address | | City | State | Phone |
| Primary Care Physician Name | | | | |
| Address | | City | State | Phone |
| OB/GYN Name (female patients) | | | | |
| Address | | City | State | 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 top Medicare for payment to me.

Signature of Patient or Authorized Guardian

Date

Anthony LaBruna, MD

Patient's Name: _____ **Allergies to Medicines:** _____
Date of Birth: _____ **Date of visit:** _____
Primary Doctor: (Name/Address): _____ **Current Medicines/ Doses:** _____
Reason for seeing the Doctor: _____

Occupation/Employer: _____
Marital Status: _____ **Name of spouse/Significant other:** _____
Children's (Names/Birthdates): _____

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

**New York-Presbyterian Hospital
Weill Cornell Medical Center**

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New York Presbyterian Hospital
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 insurance 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 may have to reschedule your appointment.

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. Brown, Kacker, Kuhel, Kutler, LaBruna, Modi, Pearlman, Prasad, Reisacher, Roure, Selesnick, Stewart, Sulica, and Voigt accept Medicare assignment, as do our Audiologists, Joseph Montano, Lisa Marie Bizzarro, 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