WEILL CORNELL PHYSICIANS

Appointment Information				
Doctor's Name: APRIL MD,MAX M	Provider # 6014	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 Replace any wrong or outdated information by crossing it out and noting the change.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	Zip	Phone

Primary Care Physician Name

Address	City	State	Zip	Phone

OB/GYN Name (female patients)

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 entitiled from governmental agencies, insurance cariers 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 snd HCFA or its intermediaries or carrieers 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* ______________

Max M. April, M.D., FAAP, FACS
Department of Otorhinolaryngology – Weill College of Cornell University

Patient's Name: ______________________ **Date of Visit:** ____________
Date of Birth : ____________ **Age :** ______ **Weight:** ________ **Height :** ____________
Reason for the visit: ______________________________
Children's Names & Birthdates : ______________________________
____

Please list all your current medications (include over-the-counter, vitamins, aspirin, herbal medications or birth control):

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

Operations	1. ____________	2. ____________	3. ____________
Hospitalizations	1. ____________	2. ____________	3. ____________
Illnesses/Injuries	1. ____________	2. ____________	3. ____________

Please list any allergies to medications, Latex of Foods :

Past or current Medical Conditions (circle Y for yes, N for no):

Constitutional
- weight gain/loss (>15 lbs) 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 ear 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
- high 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 unrination Y N
- prostate problems Y N

Skin
- past skin cancer Y N
- past radiation therapy Y N

Musculoskeletal
- arthritis Y N
- 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 problems Y N

If Yes to any of the above, please explain: ______________________________
____

Family Health/Social 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 or wk
Do you smoke? __ No, never __ No, but I used to (quit in yr. ___) Packs per day? ___ x ___ years
Do you use illicit drugs? __ No, never __ No, but I used to __ Yes Which? ____________

Reviewed by : ______________________
Max M. April, M.D.

Weill Cornell Medical College

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Department of Otorhinolaryngology
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_______________________________________ X ____________________

Signature of the patient or responsible Party **Date**