

Appointment Information				
Doctor's Name: STEWART MD, MICHAEL	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 Replace any wrong or outdated information by crossing it out and noting the change.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 top Medicare for payment to me.

Signature of Patient or Authorized Guardian

Date

Michael G. Stewart, M.D., M.P.H.

Date of Visit: _____

Patient's Name: _____ Allergies to Medicines: 1. _____

Date of Birth: _____ 2. _____

Primary Doctor: (Name/Address): _____

Current Medicines/Doses 1. _____

Occupation/Employer: _____ 2. _____

Marital Status: _____ Name of Spouse/Significant Other: _____ 3. _____

Children's Names (Birthdates): _____ 4. _____

_____ 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 all that apply) Heart Disease Diabetes Cancer Other _____
Which family member(s): _____

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: ____) Yes Packs p/day? ____ x ____ yrs

Do you use illicit drugs? No, never No, but I used to Yes Which? _____

Have you experienced any of the following? (circle Y or N or n/a)

<u>Constitutional</u>		<u>Cardiovascular</u>		<u>Genitourinary</u>	
Weight gain/loss (> 15lbs)	Y N	heart attack	Y N	frequent urination	Y N
Constant night sweats	Y N	↑ blood pressure	Y N	prostate problems	Y N n/a
		Heart murmur	Y N		
<u>Eyes</u>		<u>Gastrointestinal</u>		<u>Skin</u>	
Double vision	Y N	chronic diarrhea	Y N	past skin cancer	Y N
Glaucoma	Y N	heartburn	Y N	past radiation therapy	Y N
<u>Ear/Nose/Throat</u>		<u>Endocrine</u>		<u>Musculoskeletal</u>	
Hearing loss	Y N	diabetes	Y N	arthritis	Y N
Ear pain	Y N	thyroid disease	Y N		
Ringing in ears	Y N	autoimmune	Y N	<u>Respiratory</u>	
Balance problems	Y N			asthma/emphysema	Y N
Hearing aid	Y N	<u>Neurologic</u>		chronic cough	Y N
Difficulty breathing	Y N	headaches	Y N	Tuberculosis	Y N
Nosebleeds	Y N	seizures	Y N		
Nasal drainage	Y N	stroke	Y N	<u>Psychiatric</u>	
Sinus problems	Y N	<u>Hematology</u>		anxiety	Y N
Snoring	Y N	bruise easily	Y N	depression	Y N
Voice changes	Y N	anemia	Y N	sleep problems	Y N

If YES to any of the above, please explain: _____

Reviewed by: _____
Michael G. Stewart, M.D., M.P.H.



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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 98 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 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