Weill Cornell Medicine

PATIENT INTAKE FORM

MARIA SUURNA, MD

Patient Name: ________________________________ Date of Birth: ___________________________

Past Medical History	
☐ High blood pressure	☐ COPD
☐ Diabetes	☐ Thyroid disease
☐ Heart disease	☐ Seizures
☐ Stroke	☐ Anxiety
☐ Asthma	☐ Depression
☐ Other:	

Medications (Name, dosage)

Referring MD Name:	Primary Care MD ☐ Same Name:	Pharmacy Preference Name:
Phone:	Phone:	Phone:
Address:	Address:	Address:

Operations
1.
2.
3.

Allergies
1.
2.
3.

Reason for Visit:	Height:	Weight:

Do you drink alcohol?	☐ No, never	☐ No, but used to	☐ Yes How many drinks? ____ day/week
Do you smoke?	☐ No, never	☐ No, quit ____	☐ Yes Packs per day ___x___years
Illicit drug use?	☐ No, never	☐ No, but used to	☐ Yes Which drug?

Do you currently have any of the following problems?					
Constitutional		Respiratory		Immunologic/Allergy	
Weight gain/loss	Y N	Shortness of breath	Y N	Seasonal allergies	Y N
Fevers	Y N	Cough	Y N	Autoimmune problems	Y N
Ear/Nose/Throat		Cardiovascular		Musculoskeletal	
Hearing loss	Y N	Heart murmur	Y N	Arthritis	Y N
Ear pain	Y N	Gastrointestinal		Neurologic	
Ringing in the ears	Y N	Heartburn	Y N	Headaches	Y N
Runny nose	Y N	Diarrhea	Y N	Leg/arm weakness	Y N
Nasal bleeding	Y N	Constipation	Y N	Balance problems	Y N
Nasal congestion	Y N	Nausea/vomiting	Y N	Hematology	
Facial pain/pressure	Y N	Genitourinary		Easy bruising	Y N
Jaw pain	Y N	Frequent urination	Y N	Anemia	Y N
Sore throat	Y N	Urinary incontinence	Y N	Eyes	
Voice changes	Y N	Skin		Vision changes	Y N
Enlarged lymph nodes	Y N	Rash/moles	Y N	Glaucoma	Y N

Family History	MOTHER	FATHER	M.G. MOTHER	M.G. FATHER	P.G. MOTHER	P.G. FATHER
Heart Disease						
Cancer						
Bleeding Disorders						
Diabetes						
Thyroid Disease						
Stroke						

The above information is accurate to the best of my knowledge.

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Signature of patient or Guardian Print Name Date

REV. 03/26/2016

Reviewed by: ______________________________

Maria V. Suurna, MD

Weill Cornell Medicine

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2315 Broadway, 3rd Floor
New York, NY 10024

1305 York Avenue, 5th Floor
New York, NY 10021

Sleep Disorder Questionnaire

Weight Loss	❒ Yes	❒ No
Weight Gain	❒ Yes	❒ No
Fatigue	❒ Yes	❒ No
Daytime Sleepiness	❒ Yes	❒ No
Falling asleep driving	❒ Yes	❒ No
Snoring	❒ Yes	❒ No
Waking up at night	❒ Yes	❒ No
Restless leg	❒ Yes	❒ No
Sensations before bed	❒ Yes	❒ No
Last Sleep Study:		
If so, where?		
Obstructive Sleep Apnea Diagnosis	❒ Yes	❒ No
Apnea Severity: ❒ Mild ❒ Moderate ❒ Severe		
AHI Score		
BMI		

The Epworth Sleepiness Scale	
Take the Sleepiness Test	
What is your chance of dozing when:	
0 = none; 1 = slight; 2 = moderate; 3 = high	
Sitting and reading	
Watching TV	
Lying down to rest in the PM	
As a passenger in a car for 1 hour	
Sitting and talking to someone	
Sitting quietly after lunch	
Stopped in traffic while driving	
TOTAL	

How did you hear about us?

- The Daily News
- US News and World Report
- Facebook
- Internet Ad
- InsprieSleep.com
- NewYork-Presbyterian Press Release
- Television
- Physician:____
- Other:____

Reviewed:

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Maria V. Suurna, MD

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

REFERRING PHYSICIAN, MEDICATION AND PHARMACY INFORMATION FORM

Patient's Name:	**Date:**
Name and Address of Internist or Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	**Fax:**

MEDICATIONS

Do you have any allergies to medications? ❒ No ❒ Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

MEDICATIONS	DOSAGE (mg, teaspoon, etc)	FREQUENCY

VACCINATION HISTORY

Date of most recent Flu Shot (ages 6 mos +)	Date of most recent Pneumonia Shot (ages 65+)

PHARMACY INFORMATION

In order to expedite prescription service, if required, we would like to have your pharmacy information on file

Pharmacy Name:	
Address	
Telephone:	**Fax:**
Patient's Signature:	

REV. 03/24/2016

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

OTOLARYNGOLOGY (ENT)

PAYMENT POLICY FOR IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

- **Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**
- **Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**
- **Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**
- **Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light**.
- **Cerumen removal: Removal of wax from the ear canals.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name: ______________________________

(Print)

Signature: ______________________ **Date:** ______________________

(Patient or Responsible Party)

Weill Cornell Medicine

**Department of Otolaryngology –
Head and Neck Surgery**

Financial Policy

*Welcome to the Department of Otolaryngology-Head & Neck Surgery.
The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.*

Financial Policy

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 any question 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 and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are 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 of 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

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card 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.

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Signature of Patient or Responsible Party **Date**