Drs. Girgis & Associates, S.C.
908 N. Elm, Suite 306
Hinsdale, IL 60521
Telephone 630-323-5214 Fax 630-323-5297
www.girgisent.com

Dear Patient,

Welcome to our practice and thank you for placing your trust in us. We look forward to providing your ear, nose and throat care and would like to provide you in advance with important registration information.

Please print out and complete the Patient Forms from our website at www.girgisent.com and bring them with you to your scheduled appointment. Each form contains important information that we require for clinical, insurance and compliance purposes.

- If you are taking several medications, it is vital to have a list reporting the name of each drug currently prescribed and the dosage.
- If you were referred by a physician, please note the physician's name and address on the form provided so that we have the correct information on file to send a detailed report regarding your treatment and care.
- If you were not referred by a physician but would like a progress report sent to your family physician, please also note this information on the form provided.
- If you have had recent imaging (x-rays, CTs, MRIs) or other tests relating to the condition that you're seeing our doctors for, please bring a copy of the radiology report and/or test results with you to your appointment. You may also request that copies of your medical records be either mailed or faxed to our office. Our fax number is listed at the top of this letter.
- Please bring your insurance card and a photo ID. Copies of these documents will be retained in your file as this information is needed for billing and insurance purposes.
- If you have a co-payment, payment is due at the time of service. Your insurance card will usually display your co-payment responsibility, if any, for office or specialist visits.
- Please be aware that depending upon the nature of your visit and whether specialized tests or services such as audiology, CT scanning, nasal endoscopy or laryngoscopy are needed, your appointment can take up to one hour and sometimes longer.
- Should you find that you need to cancel or reschedule your appointment, we ask that you promptly call our office at the phone number listed above so that the appointment can be reserved for another patient.

Due to the specialty and surgical nature of our practice, the physicians are often called upon by other physicians and area hospitals to see patients on an emergency basis. Although we strive to be on time for appointments, emergency surgeries and appointments do occur. Our receptionist will notify you if there is an appointment delay due to an emergency. We truly respect and value your time and appreciate your understanding when an emergency occurs. Should you have any questions, please do not hesitate to call us. We look forward to your visit.

Sincerely,
Drs. Girgis & Associates

DRS. GIRGIS & ASSOCIATES

Breathe Better, Hear Better, Sleep Better

TODAY'S DATE _____/_____/_____ AGE: _____ MARITAL STATUS: (S M W D)

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #: _____ GENDER: (Male / Female)

PATIENT NAME: _____ NICKNAME: _____

PREFERRED LANGUAGE: _____ RACE: _____ (_____ Decline To Specify)

ETHNICITY: _____ (_____ Decline To Specify)

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Street City State Zip

EMERGENCY CONTCT: _____ PHONE: _____ RELATION: _____

PHARMACY: _____ PHARMACY PHONE; _____
Name & Address or Location

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: _____
Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY MEDICAL INSURANCE: _____
Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

POLICY NUMBER: _____ GROUP NUMBER: _____

HOW DID YOU HEAR ABOUT US?

_____PHYSICIAN (Name: _____) _____FAMILY/FRIEND (Name: _____)

_____INSURANCE (Name: _____) _____MAILER(Audiology) _____MAGAZINE (Suburban Living)

_____NEWSPAPER(Hinsdalean/OakParkLeaves/Doings/Pioneer _____DEX/YELP _____ZocDoc _____GOOGLE _____WEBSITE

_____HOSPITAL (NAME: _____) _____FORMER PATIENT

In consideration of these medical services rendered by Drs. Girgis & Associates, S.C., and the treating physician(s) I hereby assign any medical reimbursement to Drs. Girgis & Associates, S.C., and the treating physician(s).**I authorize the release of any medical information in my medical records necessary to process any insurance claim.** I understand that any fees for services rendered are my responsibility. If I am a participant in an insurance plan which requires a referral from my primary care physician and I do not have that written referral or referral number, all fees for services rendered will be my responsibility. If my health insurance policy is not in force at the time of the service, I accept full responsibility for all fees. **I authorize the release of any part of my medical record to other physicians and facilities which are participating in my care.**

_____

Patient/Responsible Party Signature Date

Drs. Girgis and Associates, S. C.
Health History (Confidential)

Patient Name: _____**DOB:**____/____/____ **Medical Record Number:**_____

What is your reason for this visit? _____

_____

PAST MEDICAL HISTORY: (Check all items that apply)
Pt = Your history FMH = Your parents, brothers or sisters have problem.

	Pt	FMH		Pt	FMH
Allergic Rhinitis			High blood pressure		
Allergy testing			High Cholesterol		
Anemia: (Type if known:_____)			History of Heart Attack: (Date: _____)		
Arthritis: □ Rheumatoid □ Osteoarthritis			HIV		
Asthma			Kidney Disease/Failure		
Atrial Fibrillation / Irregular Heart Beat			Migraine Headaches		
Blood clots			MRSA infection: (Site: _____)		
Bleeding Disorder			Multiple Sclerosis		
Cancer: (Type _____)			Parkinson's Disease		
Congestive Heart Failure			Seizures/Epilepsy		
Congenital Heart Disease			Sexually Transmitted Disease (STD)		
COPD (Emphysema)			Sinusitis		
Coronary artery disease and/or angina			Sleep Apnea		
Diabetes: □ Type 1 □ Type 2			Stroke		
Glaucoma			TIAs (mini stroke)		
Gout			Thyroid Disease □ Over Active □ Under Active		
Heartburn (GE reflux)			Other:		
Hepatitis □ A □ B □ C □ D □ E			Other:		

PAST SURGICAL HISTORY: (List surgeries)

Surgery	Year	Surgery	Year	Other Surgery	Year
□ Yes □ No Adenoidectomy		□ Tympanoplasty			
□ Yes □ No Tonsillectomy		□ Yes □ No Facial or Nasal Fracture			
□ Yes □ No Ear Tubes		□ Yes □ No Neck Surgery			
□ Yes □ No Ear Surgery		□ Yes □ No Sinus Surgery			
□ Mastoid Ear Surgery		□ Yes □ No Septoplasty			
□ Stapes ear surgery		□ Yes □ No Thyroid surgery			

SOCIAL HISTORY: (Check all items that apply)

	No	Yes	If Yes, fill out below
Do you drink alcoholic beverages?			Type of alcohol:_____ Average per week:_____
Do you currently smoke cigarettes?			Average packs per day: _____ Number of years smoked: _____
If no, have you ever smoked?			Date quit: _____
Have you ever been treated for drug or alcohol use?			
Do you use recreational drugs?			Type of drug: _____Date last used: _____
Do you have pets?:			□ Cat □ Dog □ Bird □ Other_____
Do you consume caffeine?			Amount: □ Minimal □ Moderate □ Large
Marital status: □ Single □ Married □ Widowed □ Divorced			**Last Menstrual Period:** _____
Occupation:			**Weight:** _____ **Height:** _____

ALLERGIES: Check Yes or No and complete this chart.

		Name, Brand Name, if Known	Type of Reaction
□ Yes □ No	Penicillin or Antibiotic		
□ Yes □ No	Morphine, Demerol, or Narcotic		
□ Yes □ No	Novocain or Anesthetics		
□ Yes □ No	Aspirin or Pain Medications		
□ Yes □ No	Iodine or other Contrast Dye		
□ Yes □ No	Other		
□ Yes □ No	Food Allergies		

PLEASE FILL OUT BOTH SIDES OF FORM

LIST THE MEDICATIONS THAT YOU ARE TAKING (Prescription, Over the Counter, and Herbal Medications)

Medication	Dose	Medication	Dose	Medication	Dose
Allergy Shots □ Yes □ No					

REVIEW OF SYSTEMS: (Check all items that apply)

General □ **None**	**Neck** □ **None**
□ Fever	□ Neck lumps
□ Unintentional weight change	□ Neck pain
□ Night Sweats	□ Swollen glands
Eyes □ **None**	**Cardiovascular** □ **None**
□ Change in vision	□ Chest pain
□ Double vision	□ Irregular heart beat
□ Eye pain	**Respiratory** □ **None**
Ears □ **None**	□ Asthma
□ Sudden hearing decrease □ Ear wax	□ Wheezes
□ Slowly progressive hearing loss	□ Cough with mucus
□ Ear pain	□ Dry cough
□ Ear pressure	□ Coughing up blood
□ Tinnitus (ringing or noises in the ears)	□ Shortness of breath
□ Ear drainage	**Hematologic (Blood) /Lymphatic** □ **None**
□ Exposure to loud noise	□ Bleeding problems
□ Spinning/dizziness	□ Bruises easily
Nose/Sinus □ **None**	**Gastrointestinal /(GI)** □ **None**
□ Headache	□ Heartburn
□ Facial pain	□ Nausea
□ Nasal/sinus pressure	□ Vomiting
□ Clear nasal drainage	□ Abdominal pain
□ Discolored nasal drainage	□ Increase mucus in the throat
□ Nasal congestion	**Neurological** □ **None**
□ Frequent sinus infections	□ Seizures
□ Altered sense of smell	□ Depression
□ Nose bleeds	□ Lightheadedness
□ Post nasal drip	**Endocrine (Hormones)** □ **None**
Mouth □ **None**	□ Feels cold all the time
□ Dental problems	□ Feels hot all the time
□ Recent dental work	□ Change in appetite
□ Burning tongue	□ Increased fatigue
□ Growth or sores	□ Change in hair
□ Altered sense of taste	**Allergy/Immunologic** □ **None**
□ Teeth grinding	□ Food intolerances
□ Jaw pain	□ Frequent sneezing
Throat □ **None**	□ Hives
□ Snoring	□ Post nasal drainage
□ Hoarseness	□ Nasal itching
□ Frequent throat clearing	□ Frequent colds
□ Recurrent sore throat	□ Itchy eyes
□ Difficulty swallowing	□ Redness of the eyes
□ Morning headaches	**Integumentary (Skin)** □ **None**
□ Daytime drowsiness	□ Rash
□ Frequent awakenings at night	□ New skin growth
□ Wakes up tired	□ Change in wart or mole

Referring Physician: _____ **Primary (General) Physician:** _____

Patient Signature _____ **Date** _____

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Medication History

MRN: _____

Patient Name (Print): _____ DOB: _____

Please report ALL medications taken on a regular basis, including ALL **prescriptions, over-the-counter medications, herbal remedies, and vitamin/mineral/dietary (nutritional).** The medication name, dosage, frequency and route of administration are required.

Frequency: how often the medication is taken, such as daily, twice a day, as needed, and so forth.
Route: where the medication is taken, such as inhaled, by mouth, injected into the forearm, and so forth.

Medication Name	Dosage	Frequency	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy phone:_____ Pharmacy fax: _____

Mail order pharmacy contact info: _____

I attest that the following information is accurate to the best of my ability:

_____ Date: _____
Patient Signature

(Advocate or Guardian in lieu of Patient)

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Acct #_____

Receipt of Notice of Privacy Practices & Patient Information Authorization

I, _____, hereby acknowledge receipt of the Drs. Girgis & Associates, S.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or will be made available.

I authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) may inquire regarding a medical service or billing statement, pick up records and prescriptions, and take messages pertaining to my health information.

1. _____Relationship _____

2. _____Relationship _____

I authorize Drs. Girgis & Associates to leave a message or send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information. Please initial each line that you authorize:

_____ Telephone message

_____ With a person listed above

_____ Mail to: □ Home □ Office

_____ Fax to: □ Home □ Office Fax number: (_____) _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)

Drs. Girgis & Associates, S.C. **pt acct #_____**
Financial Policy

We would like to thank you for choosing Dr. Girgis & Associates, S.C. as your medical provider. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment.

Cancelled Appointments
If you are unable to keep your appointment, please call our office within 24 hours to reschedule it. This will enable us to offer your time slot to another patient. You will also receive additional information on cancellation policies for procedures and testing in our office.

Patients Without Insurance
Full payment is expected at the time of service for office visits with the providers or audiologists and for any testing or procedures done during your visit.

Insurance
It is your responsibility to be aware of your own coverage and to ensure that your insurance is in network with our practice. If your plan is out of network, you will be expected to pay in full for your visit at the time services are rendered. We do not bill insurances that are out of network. You will be financially responsible for any services not authorized by your insurance.

If your insurance requires a referral from your primary care doctor, it is your responsibility to obtain this prior to your appointment with our providers. If you do not have this, we may reschedule your appointment.

You will be asked to present your insurance card at every visit. This is to ensure that we have your correct insurance information so that we can properly bill the visit.

Co-payments
If your plan has a co-payment, it is your responsibility to inform the front desk staff. You will be expected to pay your co-payment at check-in. We are required under agreement with your insurance to collect this co-payment from you. A $10 service charge will be assessed each time a co-pay is not paid at the time of service. This fee will also be charged if the front desk is not made aware that your plan has a co-payment.

Patient Responsibilities
In the event that your insurance has paid its portion and a balance remaining is your financial responsibility, we expect prompt payment of any co-insurance, deductibles or any other moneys due. You will be billed for any co-insurance and deductibles. We are required under our contract with your insurance to collect this money from you. All balances are to be paid in full prior to the time of your visit. Please be aware that some of the treatments or tests performed may not be covered by your insurance and may not be considered by your insurance to be reasonable and medically necessary. We will remind you of these balances when confirming your appointment so that you can be prepared to pay them when you arrive at your appointment time. If your account becomes delinquent, Drs Girgis & Associates SC reserves the right to dismiss you from the practice. If you wish to remain a patient thereafter, we will keep a copy of your credit card on file so that we may charge any future outstanding balances.

Collections
Should it become necessary for us to turn your delinquent account over to a collection agency to collect the amounts owed us under the terms of your insurance coverage, you will be held responsible for any collection agency fees and/or attorney fees which will be 25% more than the actual charges for services rendered to you in our office. Further information that is helpful or necessary for collection purposes will be forwarded to our professional collection agency.

Workmen's Compensation
If your injury is due to an accident at your work place, please be sure to contact your employer and inform them of your injury. Failure to do so may result in your claim being denied. We will need prior authorization in order to make an appointment for you. Please be prepared to give all proper information when asked, so that we can get authorization from your workmen's comp case manager. This way we will be able to bill your claim to the proper insurance company. Please bring your own insurance card to the appointment so that we can make a copy. Should workmen's comp no longer authorize visits, you will be responsible to pay at the time of service for any office visits, procedures or tests that are ordered. If the workmen's comp case goes into litigation you will be held liable for any unpaid services. If payment is not made in a timely manner your balance will be transferred to our collection agency.

Secondary and Supplemental Insurance
We will file to your secondary insurance, but be aware that not all secondary policies cover left-over balances from the primary insurance. You will be held responsible for the charges. If a co-payment is involved we will expect payment at the time of service even if you have two policies. Certain retirement plans have benefits which are based upon a complex set of patient responsibility criteria. With this type of plan, you may be responsible for a deductible and out-of-pocket maximum, over and above Medicare deductibles, before your plan will actually begin to pay benefits.

Medical Forms and Records
There is a charge of $15.00 - $35.00 for the completion of any medical forms, depending upon the number of pages and complexity of the information requested. Payment is due at the time you pick up the forms. Please allow 5-7 days to complete them. If you would like them mailed to you or to your insurance company, payment will be due prior to mailing. If you request a copy of your medical records, there will be a charge based upon the number of pages that are printed or copied. Payment for medical records will also be required prior to release.

Assignment of Benefits and Medical Records Release
I hereby authorize my insurance benefits to be paid directly to the physician signed above, realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

I have read the Financial Policy and understand and agree to adhere to this policy. **X**_____

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

Please fill out this questionnaire if you have any of the below sleep complaints.

SLEEP ASSESSMENT QUESTIONNAIRE

INSTRUCTIONS: Please answer the questions below by writing on the line provided or by checking the box that best describes you. Please select only one answer for each question.

0 – Never, **1** – Sometimes, **2** – Usually, **3** – Always

During the PAST 4 WEEKS, how often…

1. Did you snore loudly?	0	1	2	3
2. Did you choke, gasp, or stop breathing in your sleep?	0	1	2	3
3. Did you fall asleep unintentionally and/or have to fight to stay awake during the day?	0	1	2	3
4. Did you wake up feeling unrefreshed and/or feel fatigued during the day?	0	1	2	3
5. Did you have difficulty falling asleep and/or staying asleep?	0	1	2	3
6. Did sleep difficulties and/or daytime sleepiness interfere with your daily activities?	0	1	2	3
7. Did work or other activities prevent you from getting enough sleep?	0	1	2	3
8. Did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?	0	1	2	3
9. Did you have repeated rhythmic leg jerks or leg movements during your sleep?	0	1	2	3
10. Did you have nightmares, or did you scream, walk, punch, or kick in your sleep?	0	1	2	3
11. Did you have trouble using your CPAP?	0	1	2	3

Total Score: _____

This questionnaire is a modified version of the Global Sleep Assessment Questionnaire, Phannacia Corp. 2001