

Please print out the following forms.  
Then fill out the forms and fax them to our office.

Thanks!

**FAX: (312) 255-8904**



## INSURANCE INFORMATION

Please attach a copy of/ or bring insurance card(s), authorization forms and picture I.D.

MEDICARE EFFECTIVE  
NUMBER: \_\_\_\_\_ A only \_\_\_\_\_ B only \_\_\_\_\_ A&B \_\_\_\_\_ DATE: \_\_\_\_\_

PRIMARY CARE PROVIDER: \_\_\_\_\_ TPL NUMBER: \_\_\_\_\_

IDPA CASE #: \_\_\_\_\_ IDPA RIN ID: \_\_\_\_\_

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PRIMARY INSURANCE: \_\_\_\_\_ TEL#: \_\_\_\_\_

CLAIM FILING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

POLICY#: \_\_\_\_\_ GROUP#: \_\_\_\_\_ EFF. DATE: \_\_\_\_\_

HOLDER NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ CO-PAY: \$ \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ TEL. #: \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ NOTATIONS:

SECONDARY INSURANCE: \_\_\_\_\_ TEL. #: \_\_\_\_\_

CLAIM FILING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

POLICY#: \_\_\_\_\_ GROUP#: \_\_\_\_\_ EFF. DATE: \_\_\_\_\_

HOLDER NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ CO-PAY: \$ \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ TEL. #: \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ NOTATIONS:

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I have read and understand the payment and billing policies given to me. I understand that I am financially responsible for charges not paid by my medical insurance. I authorize any holder of medical information about me to release to any responsible health carrier and/or the Social Security Administration or its intermediaries, any information for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the Dept. of Oto-HNS for bills or services furnished to me during the period \_\_\_\_\_ to \_\_\_\_\_

Print Patient Name/Legal Guardian: \_\_\_\_\_

Signature of Patient/Legal Guardian: \_\_\_\_\_



## Review of Systems

Are you currently, or have you had, problems with:

### *Constitutional*

Weight Gain                      Yes   No  
Weight Loss                      Yes   No  
Night Sweats                    Yes   No  
Insomnia                         Yes   No

*Circle One*

### *Neurological*

Numbness                        Yes   No  
Dizziness                        Yes   No  
Stroke                            Yes   No  
Headaches                       Yes   No

*Circle one*

### *Eyes*

Double Vision                    Yes   No  
Visual Loss                       Yes   No

### *Psychiatric*

Depression                      Yes   No

### *Ear, Nose, Throat and Mouth*

Hearing loss                    Yes   No  
Noise/ringing in ears           Yes   No  
Drainage from the ear           Yes   No  
Right side \_\_\_ Left Side \_\_\_ Both \_\_\_  
Vertigo, Imbalance or dizziness   Yes   No  
Fullness or pressure in ear      Yes   No  
Right side \_\_\_ Left Side \_\_\_ Both \_\_\_  
Nasal Congestion               Yes   No  
Nasal Drainage                 Yes   No  
Difficulty breathing through the nose   Yes   No  
Nose bleeds                     Yes   No  
Frequent Sinus infections       Yes   No  
Frequent sore throat            Yes   No  
Trouble swallowing             Yes   No  
Hoarseness                      Yes   No  
Choking or Coughing            Yes   No  
Throat clearing or gagging      Yes   No  
Frequent cough                 Yes   No

### *Allergic/Immunologic*

Sneezing                        Yes   No  
Itchy eyes/nose                 Yes   No  
Itchy throat                     Yes   No  
Skin rash                        Yes   No  
HIV/AIDS                       Yes   No

### *Respiratory*

Asthma                          Yes   No  
Cough up blood                 Yes   No  
TB                                Yes   No  
Pneumonia                       Yes   No  
Trouble breathing at night      Yes   No  
Snoring                         Yes   No

### *Gastrointestinal*

Bladder trouble                 Yes   No  
Kidney disease                 Yes   No  
Arthritis                        Yes   No

### *Cardiovascular*

Chest pain or angina            Yes   No  
Heart trouble                    Yes   No  
Heart murmur                    Yes   No  
High blood pressure             Yes   No

### *Endocrine*

Diabetes                         Yes   No  
Thyroid disease                 Yes   No

### *Hematologic*

Bleeding disorders              Yes   No  
Easy bleeding                    Yes   No

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

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

I have reviewed the above information with the patient.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*