



## **OTOLARYNGOLOGY PLASTIC SURGERY ASSOCIATES**

SEAN M SMULLEN, MD  
STEPHEN C MASS, MD  
RICHARD HERMAN, MD  
SONYA WEXLER, MD

Julie M Roper, MA, CCC-A  
Tina D Rice, Au.D, CCC-A  
Melinda Scholl, MA, CCC-A  
Mary Gracey, MA, CCC-A  
Rian A. Shapiro, Au.D, CCC-A  
Gale Schwartz, MS, CCC-A

Welcome to our practice.

We look forward to aiding you with your healthcare needs.

Please complete the enclosed paperwork before you come into the office. If you come for your appointment, without the paperwork completed we may re-schedule your appointment. Please arrive at least 15 minutes prior to your appointment time.

We are affiliated with Doylestown Hospital and Grand View Hospital. Please let us know if you have had any procedures or testing done at either location and we will obtain copies for your record. Please bring copies of testing/procedures from any other facility with you.

If you are being seen for sinus issues and have had a CT scan of your sinuses, please bring a copy of the disc with you for review by the doctor.

If your insurance requires a referral to be seen, you must call and request it from your Primary Care (family) Doctor. Your doctor may require 48-72 hours to process your request. Our NPI# for your referral is 1487717575.

We realize this paperwork takes time and we appreciate your thoroughness.

Sincerely,

Otolaryngology Plastic Surgery Associates, PC

Doylestown: Doylestown Pointe, 103 Progress Drive, Suite 200 Doylestown PA 18901 / 215-348-1152  
Lansdale: North Penn Medical Arts Center, 2100 North Broad Street Lansdale PA, 19446 / 215-368-5290  
Sellersville: The Summit, 920 Lawn Avenue, Suite 7, Sellersville, PA 18960 / 215-453-8900

[www.ent-drs.com](http://www.ent-drs.com)

**OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.**  
**NEW PATIENT PAPERWORK**

NAME: \_\_\_\_\_  
Last, First, Middle Initial

REFERRING DOCTOR: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RACE: PLEASE CHECK ANY BOX THAT APPLIES

- White
- Black/African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Decline to answer

Please only provide phone numbers you will answer or check for a message

CELL PHONE # \_\_\_\_\_

ETHNICITY: PLEASE CHECK A BOX

- Spanish/Hispanic Origin
- Not Hispanic or Spanish Origin
- Decline to answer

HOME PHONE # \_\_\_\_\_

EMAIL: \_\_\_\_\_  
(only used for reminders and/or newsletter)

PREFERRED LANGUAGE (if other than English)

DATE OF BIRTH: \_\_\_\_\_

SEX:  M  F

Identify As: \_\_\_\_\_

**IMPORTANT**

**LOCAL PHARMACY NAME:**

**INSURANCE INFORMATION**

Insurance: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

Group Name & Number: \_\_\_\_\_

Subscriber  Yes  No

If you are not the subscriber complete below:

Subscriber name: \_\_\_\_\_

Subscriber D.O.B. \_\_\_\_\_

Are you covered by any other insurance Plans?

Yes  No

If yes, please provide the name and ID number below:

\_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

PHARMACY LOCATION: \_\_\_\_\_

ARE YOU EMPLOYED?  YES  NO

EMPLOYER: \_\_\_\_\_

FULL-TIME STUDENT:  YES  NO

IS PATIENT IN HOSPICE CARE?  YES  NO

MARITAL STATUS:  Single  Married  Divorced

Domestic Partner  Widow

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC. P.C.  
FINANCIAL POLICY

**PATIENT NAME:** \_\_\_\_\_

Thank you for choosing us as your health care provider. Our priority is that you receive comprehensive care and treatment to restore you to good health. Outlined below is information to assist you in understanding your financial responsibility in relation to our Financial Policy.

**REFERRALS:**

At all times, it is the *responsibility of the patient* to ensure we (OPSA) have received a referral prior to your visit in our office. It is also the *responsibility of the patient* to confirm that all pre-certifications or authorizations, needed for a surgery or test, have been obtained by OPSA, prior to proceeding with any planned surgery or testing. If the proper referrals, pre-certifications or insurance authorizations are not in place, at the time of a scheduled office visit, surgery, or testing, cancellation and rescheduling may be necessary.

**ASSIGNMENT OF BENEFITS:**

Signing the Assignment of Benefits authorizes your insurance company to make payment directly to the treating medical provider (OPSA). We will submit a claim to the insurance company on your behalf, however, if the insurance company does not pay your balance in full, within 30 days, we may ask that you contact them. Co-pays are due at the time of service, this includes any due for a dependent child visit, the accompanying adult will be responsible on the day of service. You will be billed for any deductibles, co-insurance or non-covered services, as dictated by your insurance company benefit.

**NO-SHOW APPOINTMENTS:**

Our schedules are very busy and we work to accommodate our patients. We ask that you give us the courtesy of 24 hours' notice when cancelling an appointment. If we don't hear from you and you do not show up for your scheduled visit, we reserve the right to charge a fee of \$40.00. Payment is required prior to rescheduling the missed appointment.

**FMLA/DISABILITY/ETC FORMS:**

There is a fee for completion of forms. We cannot list all forms here, the following is a small sample of the types of forms we complete; school physical, camp, sports, disability, return to work, gym releases and FMLA. You should discuss what you need with our billing representatives. Payment is due upon completion of forms.

**COLLECTIONS:**

You will receive a statement if you are responsible for a balance on your account. Accounts are considered delinquent if unpaid after 90 days and will be turned over to a collection agency without notice. You will be responsible for all reasonable collection costs at the time the account is considered delinquent.

For your convenience, we accept Visa, Mastercard, Discover, American Express, check, cash or money order. There will be a \$45.00 fee for returned checks.

If you have any questions about our Financial Policy, please contact our billing office at 215-368-5290 Ext 211 or 212.

My signature below acknowledges receipt and understand of my obligations, based on my insurance and the above Financial Policy of Otolaryngology Plastic Surgery Assoc., P.C.

**Patient** or (Guardian Signature) \_\_\_\_\_ Date: \_\_\_\_\_

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC. P.C.  
FINANCIAL POLICY

**PATIENT NAME:** \_\_\_\_\_

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits to be paid directly to the undersigned physicians of Otolaryngology Plastic Surgery Assoc., P.C. I am financially responsible for the non-covered services. I authorize the physician to release any information required, to my insurance company, for payment of services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify Otolaryngology Plastic Surgery Assoc., P.C. of any change in my health insurance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HIPAA Policy**

**HIPPA Privacy Questions**

We will ask you to sign an electronic signature pad to confirm that you have been informed of our HIPAA Privacy Policy. Our HIPAA Policy is posted on our website [www.ent-drs.com](http://www.ent-drs.com). A copy is available upon request.

Please select Y-Yes or N-No to tell us how we can communicate with you.

**Leave appointment message on:**

Home Phone	Y	N
Cell Phone	Y	N
Mobile Text	Y	N
With another person?	Y	N

**Leave other medical info on:**

Home Phone	Y	N
Cell Phone	Y	N
With another person	Y	N

Please indicate below the name and relationship of anyone we are allowed to share your private health information (PHI) with.

I authorize OPSA to share my PHI with the individuals listed below:

\_\_\_\_\_ (name, relationship and phone number)

\_\_\_\_\_ (name, relationship, and phone number)

\_\_\_\_\_ (name, relationship, and phone number)

## **PATIENT DISCLAIMER AND ACKNOWLEDGEMENT**

The physicians of Otolaryngology Plastic Surgery Associates, P.C., are pleased to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Otolaryngology Plastic Surgery Associates, P.C., is working with Penn Medicine to improve the quality of care provided to its patients.

Otolaryngology Plastic Surgery Associates, P.C., is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by the physicians of Otolaryngology Plastic Surgery Associates, P.C. Each physician affiliated with Otolaryngology Plastic Surgery Associates, P.C., exercises independent medical judgement in the care of his or her patients.

If you have any questions about the relationship that Otolaryngology Plastic Surgery Associates, P.C., has with Penn Medicine, please ask your physician.

Please sign below to indicate that you have read this acknowledgement and have had an opportunity to ask questions.

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Patient signature

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Date

**OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.**  
**INSURANCE RESPONSIBILITY**

**PATIENT NAME:** \_\_\_\_\_

You, and/or your referring physician, have determined that you require the expertise of Otolaryngology Plastic Surgery Associates to diagnose and treat your ear, nose or throat problem. We appreciate the opportunity to help you in achieving a good outcome. As specialist in Otolaryngology, we will provide the necessary testing and treatment to diagnose you and help you to improve your current health problem.

Listed below are *some* of the procedures and treatments that *may* be done during your office visit. Your insurance company may choose to process these procedures and treatments differently than an office visit. We will bill your insurance for the visit and any procedure or treatment you require. *Your insurance* will determine if you are required to pay any additional co-pay, deductible or co-insurance.

It will be your responsibility to pay the additional co-pay, deductible or co-insurance as dictated by your insurance company.

Below is a list of the most common office procedures/treatments we provide.

- 30901 Control of Nasal Hemorrhage, Simple
- 30903 Control of Nasal Hemorrhage, Complex
- 31231 Diagnostic Nasal Endoscopy
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)
- 31238 Nasal Endoscopy with Cautery of Blood Vessels
- 31575 Flexible Laryngoscopy
- 69210 or G0268 Removal of Impacted Cerumen
- 69420 Myringotomy
- 69433 Myringotomy and Tube Placement
- 92557 Audiogram
- 92567 Tympanogram

Your signature below acknowledges receipt and understanding of your insurance obligations.

Signature – Patient/Responsible Party: \_\_\_\_\_

PRINT NAME SIGNED ABOVE: \_\_\_\_\_

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.  
MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

What Laboratory do you use:  Quest Diagnostics  Lab Corp.  Other: \_\_\_\_\_

**ALLERGIES**

Latex Allergy:  YES  NO

MEDICATION ALLERGIES:  NO  YES – If yes, what? \_\_\_\_\_

**CURRENT MEDICATIONS**

If you are not taking any PRESCRIPTION MEDICATIONS, PLEASE CHECK THIS BOX

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE TAKING – If you need more room please list on a separate sheet.

Medication	Dosage	How often taken

If you use any over the counter medications or supplements, please list below

Over the Counter Medications/Supplements	Dosage	How often taken

**SOCIAL HISTORY**

TOBACCO USER:  NO  YES –  tobacco  pipe  cigars  vape

If yes, how many? # Per day \_\_\_\_\_ # Per week \_\_\_\_\_

FORMER TOBACCO USER- How long? \_\_\_\_\_

ALCOHOL INTAKE:  NO  YES If yes, how many drinks per day? \_\_\_\_\_ or week \_\_\_\_\_

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.  
MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_

**FAMILY HISTORY: ex: does your parent/sibling have any of the following:**

ALLERGIES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
ASTHMA	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
BLOOD DISEASE	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
CANCER- TYPE _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
DIABETES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
ECZEMA	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
HEARING DEFICIENCY	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
MIGRAINES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
RENAL DISEASE	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
SEIZURE DISORDER	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER
OTHER: _____	<input type="checkbox"/> MOTHER	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	<input type="checkbox"/> BROTHER		

**YOUR PAST MEDICAL/SURGICAL HISTORY:**

**CARDIOVASCULAR**

Coronary Artery Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Heart Attack	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Elevated Cholesterol	<input type="checkbox"/> NO	<input type="checkbox"/> YES
High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Stroke	<input type="checkbox"/> NO	<input type="checkbox"/> YES

**GASTROINTESTINAL**

Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Gastroesophageal Reflux	<input type="checkbox"/> NO	<input type="checkbox"/> YES

**GENITOURINARY**

Renal Failure (acute)	<input type="checkbox"/> NO	<input type="checkbox"/> YES
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**EAR/NOSE/THROAT: (HEENT)**

Cataracts	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Glaucoma	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Chronic Ear Infections (Otitis Media)	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Hearing Loss	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Right Ear	<input type="checkbox"/>	
Left Ear	<input type="checkbox"/>	
Currently Using Hearing Aid/Aids	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Sinus Problems (Chronic Sinusitis)	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Nasal Polyps	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Nasal Allergies	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Recurrent Tonsillitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Tinnitus	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Vertigo	<input type="checkbox"/> NO	<input type="checkbox"/> YES
History of Falls	<input type="checkbox"/> NO	<input type="checkbox"/> YES

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.  
MEDICAL HISTORY

**PAST MEDICAL/SURGICAL HISTORY:**

**HEMATOLOGIC**

Anemia  NO  YES  
Bleeding Disorder  NO  YES

**IMUNOLOGIC**

Seasonal Allergies  NO  YES

Type: \_\_\_\_\_

Food Allergies  NO  YES

Type: \_\_\_\_\_

HIV/AIDS  NO  YES

Multiple Sclerosis  NO  YES

**INTEGUMENTARY**

Eczema/Psoriasis  NO  YES

**INFECTIOUS DISEASE:**

Mononucleosis  NO  YES

**METABOLIC/ENDOCRINE**

Diabetes  NO  YES

Type: \_\_\_\_\_

Thyroid Deficiency  
(Hypothyroidism)  NO  YES

Thyroid excess  
(Hyperthyroidism)  NO  YES

**MUSCULOSKELETAL**

Arthritis  NO  YES

**NEOPLASTIC**

Cancer  NO  YES

Type: \_\_\_\_\_

**NEUROLOGIC**

Migraine  NO  YES

Parkinson's  NO  YES

Seizure Disorder  NO  YES

**OBSTETRIC**

Currently Pregnant  NO  YES

If yes – Due Date \_\_\_\_\_

**PSYCHIATRIC**

Depression  NO  YES

Drug Addiction  NO  YES

**PULMONARY**

Asthma  NO  YES

COPD/Emphysema  NO  YES

Sleep Apnea  NO  YES

Tuberculosis  NO  YES

**HISTORY OF HEAD/NECK SURGERY:**

TYPE: \_\_\_\_\_

**INJURY**

Date: \_\_\_\_\_

Head  NO  YES

Facial Fracture  NO  YES

Injury Due to:  MVA  Work related

OTOLARYNGOLOGY PLASTIC SURGERY ASSOCIATES, P.C.  
Review of Systems – Check any symptoms you may be experiencing

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Eye Problems**

Double vision    Glaucoma    Visual Loss

**Ear Problems**

Ear Drainage    Hearing Loss    Ear infections    Itchy    Wax    Ringing/noise in ears    Ear Pain

**Nose & Sinus Problems**

Chronic Congestion    Nosebleeds    Runny nose    Postnasal Drip    Facial Pain

**Mouth & Throat Problems**

Difficulty Swallowing    Snoring    Sore Throat    Hoarseness

**CARDIOVASCULAR - Heart & Circulation Problems**

Chest Pain    Hypertension    High Cholesterol    Heart Attack

**RESPIRATORY - Lung or Respiratory Problems**

Shortness of Breath    Wheezing    Cough    Sleep Apnea    Asthma

**GI -Stomach problems**

Abdominal Pain    Heartburn    GERD

**Musculoskeletal**

Arthritis    Joint Pain

**Skin Problems**

Rash    Latex allergies    Urticaria/hives

**NEUROLOGICAL - Brain or nervous system problems**

Headache    Seizures    Weakness    Dizziness

**ENDOCRINE - Glands & Hormone Problems**

Intolerance to heat or cold    Diabetes    Thyroid problems

**HEMATOLOGIC - Blood or Lymph Nodes Problems**

Bleeds excessively after injury    Bruises easily

**IMMUNOLOGICAL**

Immune deficiency    HIV/Hepatitis