

## Please check this box if you need a school/camp/work note for today

Patient Name:			Date of Birth:		Gender	
Address:		City, S	State Z	Zip		
Phone 1	Phone 2			Email		
PCP		Phar	macy			
			·			
Primary Insurance	М	ember II	D		Copay	
Cacandary Incurance					Conov	
Secondary Insurance No seco	ondary insurance	Member	ID		Copay	
Reason for Visit					MY ENT RECORDS	
EARS Pain NOSE Infection	THRO Nasal Congestion Nosebleeds	TAC	_	ue/Lip Tie l Issues	Sent via FAX/email I have them with me	
Hearing	Sinus Disease		Sleep l	Issues	PCP notes	
Speech	Enlarged Adenoids		Strep 1	Issues	ER/Urgicare/Hosp notes	
Wax	Nasal Fracture		Neck	Mass	Sleep study	
Something in the ear	Something in the nose		Thyro	oid Issues	Audiology	
Ringing (Tinnitus)	Deviated Septum		GE Re	eflux	Specialist Notes	
Dizziness (Vertigo)	Smell/Taste Issues		Trach		Imaging-CT/MRI/Xray	
	Other	_	Other.		Other	
Other  I am responsible for the full am	ount of the visit +\$50	if my ins	urance	lapsed or if there i	is another insurance policy	
I am responsible for a \$25 fee for		•		-	• •	
I am responsible for a \$100 fee f	for surgery no-show or	r non-me	dical ca	ncellation		
By signing this form, I attest th	at all information on t	his form	is corre	ect, complete and i	up-to-date	
	" .I " "C.I "				DATE MANDONON	
Patient or Parent signature followed by		*****	*****	*****	DATE: MM/DD/YYYY	
Height in inches	Weight in pound			Temp in degre		

Kidney stones





## REVIEWED BY DR. RESPLEI

			REVIEWED BY DR. RESPLEK						
GENERA Yes No	L	BLOOD		ALLERGI Yes No	ES (please list)	ENT IS Yes No	SUES		
	Recent Weight Gain	Yes No	Bleeding		Medicine		Ear Pain		
	Recent Weight Loss		Tendency		Food		Hearing Difficulty		
	Fatigue		Anemia		Environmental		Swallowing Difficulty		
	Chills/Fever		Swollen Glands	MEDICIN	NES (please list)		Ringing in Ears		
	Night Sweats		HIV	Yes No	Antibiotics		Vertigo		
	Change in Sleep Habit	S GASTRO	0		ENT Drugs		Frequent Sore Throat		
CARDIO		Tes IV	Nausea		Other Other		Post Nasal Drip		
Yes N	Chest pain			HISTOF	RY (please explain)		Nasal Stuffiness		
	Irregular heartbeat		Vomiting	Yes N	0		Bad Breath		
	Heart disease		Diarrhea		Prenatal		Cough		
	High blood pressure		Constipation	1	History		Sinus trouble		
	Heart murmur		Bloody/black stoc	ols	Speech		Restless Sleep		
			Hiatal Hernia		Immunizations		Mouth Breathing		
	Difficulty Breathing		Hepatitis		COVID		Snoring		
	Noisy Breathing	ENDO( Yes N	lo	Ves I	RONMENT		Headache		
	Positive TB test		Hot/Cold intoler	ance	Smoking at hor	ne	Sleep Apnea		
CIGINI	Swollen feet		iVoice change		Pets		Neck Mass		
SKIN Yes No	CI. I.		Energy changes		Daycare		GE Reflux Disease		
	Skin Lesions		Excessive thirst		School		Tongue Toe		
	Rashes/Eczema		Goiter		Bottle Use		Diminished Smell		
	Color Changes	HISTOR Yes No			Alcohol		Hearing Aid (s)		
	Hair Changes	res No	Ear Infections	OTHE	R		Trach/ size		
	Nail Changes		Asthma	Yes	Feeding Issues	***	********		
	Easy Bruising		Bronchitis		Bed Wetting	i	REASON FOR ENT VISIT		
	Itching		Pneumonia		Thumb Suckin	<sub>σ</sub> AL	LERGY/MEDICATION LIST		
EYES Yes No			Tonsilitis		Speech Issues	A A	ND ANY OTHER ISSUES:		
	Pain		Strep		Drooling				
	Vision Loss		Laryngomalacia		Nightmares				
	Double Vision		Croup		Genetic Syndro	nme			
	Excessive teasring		Hospitalizations		Developmental 1				
	Eye infections		Injuries		Learning Issues				
	Eyeglasses/contact lens	es	Surgeries		Autism	•			
UROLOG Yes No	iY	£AMII.	C	ho?	Hyperactivoty				
103 140	Difficulty Urinating		Sleep Apnea		Behavioral Issue	es			
	Pain or Burning		Ear Infections		Balance problem				
	Blood in Urine'		Asthma		Puts things in N				
	Frequent urination		Hearing Loss		Puts things in F				
	Kidney infection		GE Reflux Tongue/Lip Tie		Tato timigo iii I				

DR. DON RESPLER 2 SOUTH SUMMIT AVENUE HACKENSACK, NJ 07601 (201) 996-9200



This form protects the privacy of your medical records and directs our office to release your medical information *only* to those people and entities that you choose below. Please be sure to include every doctor, school and person with whom you would like us to share your medical information

Name:	Date of Birth:						
Address:		City, State Zip					
Phone 1	Phone 2		Email				
Other than my PCP, insurance and ENT referral for coordination of ENT treatment, I authorize this office to share my medical information with the following individual(s), department(s), doctor(s), relative(s), school(s) and/or office(s)							
Name or Entity		relationsh	nip co	ontact info			
Name or Entity		relationsh	nip co	ontact info			
Name or Entity		relationsh	nip co	ontact info			
Name or Entity		relations	hip c	contact info			
I understand that I have a right to revolution HIPAA form must include my name, adbeen already made in reliance of today  I confirm that this HIPAA direct	dress, contact informat 's HIPAA authorization	ion and signature This HIPAA form v	and will not affect any will remain in force un	disclosure that has til revoked or replaced			
i commin that this nipaa direct	live reflects my wishes	and has been com	ipteted and signed vot	untarity.			
Patient or Parent/Guardian/Represent	tative signature		DATE:	MM/DD/YYYY			
Please print name of signer, and relation	nshin (Patient mothe	r father Legal gua	ardian etc)				

For any questions or objections, please contact our HIPAA team at 201-996-9200 or via email at angelsofENT@gmail.com