ENT Institute of NJ

DR. RESPLER OFFICE VISIT FORM

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

Patient Name:

Date of Birth:

Gender

Address:

City, State Zip

Phone 1

Phone 2

Email

PCP

Pharmacy

Primary Insurance

Member ID

Copay

Secondary Insurance

☐ No secondary insurance

Member ID

Copay

Reason for Visit

EARS

- ☐ Pain
- ☐ Infection
- ☐ Hearing
- ☐ Speech
- ☐ Wax
- ☐ Something in the ear
- ☐ Ringing (Tinnitus)
- ☐ Dizziness (Vertigo)
- ☐ Hearing Aid(s)
- Other_____

NOSE

- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Sinus Disease
- ☐ Enlarged Adenoids
- ☐ Nasal Fracture
- ☐ Something in the nose
- ☐ Deviated Septum
- ☐ Smell/Taste Issues
- ☐ Other_____

THROAT

- ☐ Tongue/Lip Tie
- ☐ Tonsil Issues
- ☐ Sleep Issues
- ☐ Strep Issues
- ☐ Neck Mass
- ☐ Thyroid Issues
- ☐ GE Reflux
- ☐ Trach
- ☐ Other_____

MY ENT RECORDS

- ☐ Sent via FAX/email
- ☐ I have them with me
- ☐ PCP notes
- ☐ ER/Urgicare/Hosp notes
- ☐ Sleep study
- ☐ Audiology
- ☐ Specialist Notes
- ☐ Imaging-CT/MRI/Xray
- Other _____

☐ **I am responsible for the full amount of the visit +$50 if my insurance lapsed or if there is another insurance policy**

☐ **I am responsible for a $25 fee for any office no-shows or same day cancellation**

☐ **I am responsible for a $100 fee for surgery no-show or non-medical cancellation**

☐ **By signing this form, I attest that all information on this form is correct, complete and up-to-date**

Patient or Parent signature followed by "mother" or "father"

DATE: MM/DD/YYYY

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Height in inches

Weight in pounds

Temp in degrees F