Diplomates
American Osteopathic College
Of Otolaryngology

GERALD WEST, D.O., F.O.C.O.O.
RICHARD C. SCHARF, D.O., F.A.O.C.O.
LOUIS J. CONTE, D.O., F.A.O.C.O.
MILO BASTIANELLI, D.O., F.A.O.C.O.
THOMAS F. MAZZONI, D.O., F.A.O.C.O.

Otology
Rhinolaryngology
Facial Plastic Surgery
Head and Neck Surgery

505 CHESTNUT STREET
ROSELLE PARK, NEW JERSEY 07204
(908) 241-0200

778 KENNEDY BOULEVARD
BAYONNE, NEW JERSEY 07002
(201) 823-2977

PATIENT REGISTRATION/INSURANCE UPDATE - PLEASE PRINT

FIRST NAME:_____ LAST NAME:_____ SEX: M F DATE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE#_____ WORK PHONE #_____ CELL PHONE #_____

DATE OF BIRTH:_____ MARITAL STATUS _____ EMAIL: _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

SOCIAL SECURITY#_____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT:_____ PHONE #_____

EMPLOYER:_____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PRIMARY INSURANCE COMPANY:_____ PHONE #_____ ID#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURED:_____ DATE OF BIRTH:_____ RELATIONSHIP:_____

SECONDARY INSURANCE CO._____ PHONE #_____ ID#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP_____

INSURED:_____ DATE OF BIRTH:_____ RELATIONSHIP:_____

COMPLETE IF ACCIDENT: DATE:_____ TYPE: ☐ AUTO ☐ WORKER'S COMP. ☐ OTHER_____

INSURANCE CO.:_____ ADDRESS:_____ PHONE #_____

CITY_____ STATE_____ ZIP_____ CLAIM#_____

ATTORNEY:_____ PHONE #_____ ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

INSURANCE AUTHORIZATION STATEMENT

"I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Doctors West, Scharf, Conte, Bastianelli, and Mazzoni for any services furnished me by that physician or his designee. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services."

PATIENT'S SIGNATURE:_____ DATE:_____

WSCB

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MEDICAL HISTORY

Name_____ **Date** _____

Reason for visit _____

Pharmacy _____ **City** _____ **State** _____

Primary Care Physician _____

CIRCLE ONE:

NO YES Are you now taking any drugs or medications? How Often? List them if possible:

_____

NO YES Do you have allergies? If yes, list them_____

_____

NO YES Have you ever received local anesthesia (novocaine or xylocaine) by a dentist or doctor? Circle proper response

NO YES Have you ever received general anesthesia?

NO YES Did you ever have a bad "reaction" to anesthesia?

EXPLAIN: _____

CIRCLE IF YES: DO ANY FAMILY MEMBERS HAVE:

Heart trouble, excessive bleeding tendencies, tuberculosis, high blood pressure, diabetes, psychiatric or "nerve problems", excessive bruisability, thyroid problems, excessive scarring, asthma, cancer

CIRCLE IF YES: HAVE YOU EVER HAD:

Heart trouble, blood pressure related problems, asthma or other respiratory problems, liver, gall bladder trouble, hepatitis (yellow jaundice), AIDS (HIV) exposure, kidney disease, diabetes, bleeding tendencies, epilepsy, convulsions or seizures, any broken bones of the face, neck, jawbones or back; back trouble, abnormal chest x-rays, abnormal electrocardiogram (EEG), any part of your body paralyzed or numb, any other illnesses? IF YES, EXPLAIN _____

_____

_____

LIST ALL PREVIOUS SURGERIES: _____

_____

CIRCLE IF YES: DO YOU

Wear contact lenses, have dentures, caps or bridges; smoke, drink alcohol, have any loose teeth or gum disease; object to blood transfusions. Are you pregnant? _____

HAVE YOU EVER CONSIDERED COSMETIC SURGERY?

❑ Nose ❑ Ear Positioning ❑ Facelift ❑ Eyelid ❑ Scar Revision

❑ Correction of Wrinkles ❑ Liposuction of Face ❑ Other

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Medical History Form

Name: _____ **Date:** _____

Current Medications:

_____

_____

Medical Problems:

_____

_____

_____

Family Medical Problems:

Mother: _____
Father: _____
Brother: _____
Sister: _____
Grandfather
(Mother's Father): _____
Grandmother
(Mother's Mother): _____
Grandfather
(Father's Father): _____
Grandmother
(Father's Mother): _____

Surgical History (Please list any surgeries you have had):

_____

_____

Social History:

Do you use tobacco (smoke/dip/vape): YES ___ NO____ How often? _____
Do you drink alcohol: YES ____ NO _____ How often? _____

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In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs and continue to accept or participate in other insurance plans.

While we are pleased to be able to provide this service to you, it is very difficult for us to be aware of all the individual requirements of each plan. Each has different stipulations regarding how often services may be rendered and even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon the type of contract your employer has negotiated.

If your insurance plan requires authorization (referral) from your primary care physician, it is your responsibility to present it to our staff upon arrival. It is also your responsibility to be aware of the number of visits you have. If you do not have the appropriate authorization, we will be happy to reschedule your appointment or you may see the doctor and pay for today's visit.

IF YOU ARE SEEN AND WE LATER FIND THAT YOUR REFERRAL IS NOT VALID, YOU WILL BE BILLED FOR THAT VISIT.

If your insurance requires a co-payment, it is due at the time of service. Co-payments are a requirement of our participation with your insurance company and will not be billed. **We accept cash, personal checks, Mastercard and Visa.**

Unfortunately, if you do not inform us of any special requirements or limitations in your contract and we subsequently order services that are not covered, such as lab work or hospitalization or provide medical supplies that are not covered; we or the selected facility will have no choice but to bill you directly for those charges. Payments for those charges are your responsibility and payment is due immediately.

With your cooperation and help, you should be able to receive all the benefits offered to you and we will be able to concentrate on caring for your medical needs.

I have read and understand the office policy and agree to accept responsibility for payment in full for non-covered services and/or supplies, co-payments and non-referral visits.

Patient's Signature_____ **Date**_____

WSCB

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Drs. West, Scharf, Conte, Bastianelli and Mazzoni

Print Patient Name: _____

Signature of Patient: _____

Date: _____

*If person signing is not the patient, please print your name and relationship to patient:

_____

Patient/representative refused to sign. Employees Initials _____ Date: _____

If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement _____

_____

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes _____ No _____