Anthony Sparano, M.D.
Facial Plastic Surgeon

Sparano Face & Nasal Institute
NJ Institute for Robotic Hair Surgery
Skin Sense Spa

Patient Name: _____ DOB: _____ Date:_____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

E-mail Address: _____

Please check box if you'd like to be notified of specials, events or to receive educational information. Yes [ ] No [ ]

Address: _____ City: _____

State: _____ Zip Code: _____ Social Security Number: _____-_____-_____

Marital Status: Married / Single / Divorced / Widowed / Legally Separated Sex: Male [ ] Female [ ]

Race: Caucasian / African American / Asian / Native America / Other Race Ethnicity: Latino / Hispanic / Other

Employer: _____Occupation:_____

Employer Address:_____ City: _____State:_____ Zip:_____

Work Phone: (_____)_____-_____

Emergency Contact: _____Relation:_____Contact Phone: (_____)_____-_____

If patient is a minor: Guardian/Guarantor_____ _____Relation:_____ DOB _____

Guardian Contact Phone: (_____)_____-_____

Primary Care Physician: _____

Please let us know how you heard about us (circle/complete all that apply):

Patient/Friend (specify):_____ Internet

Newspaper (specify):_____ Magazine (specify): _____

Referring Physician (specify):_____ Educational Seminar (specify): _____

Spa/Salon/Soul Focus (specify): _____ Gym (specify): _____

Other (specify): _____#

Insurance Information

Primary Insurance: _____Subscriber Name & DOB: _____

Secondary Insurance: _____Subscriber Name & DOB: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: (_____) _____-_____

Assignment and Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the above noted insurance company and assign directly to Anthony Sparano, M.D., all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date:_____

Patient Name:_____ DOB:_____ Date:_____

Medications:

Name	Dose (e.g., 10mg daily)

Drug Allergies:

Name	Reaction (e.g., hives)

Non-Drug Allergies:

Name	Reaction (e.g., hives)

Previous Medical Illnesses (please circle Y or N)

Anemia	Y	N	Depression	Y	N	Heart Murmur	Y	N
Anxiety	Y	N	Diabetes	Y	N	Hepatitis	Y	N
Asthma/COPD	Y	N	Glaucoma	Y	N	HIV	Y	N
Cataract	Y	N	Heart Disease	Y	N	Hypertension	Y	N

Additional Previous Illnesses:_____

Previous Surgeries:

Surgery	Year

Patient Name:_____ DOB:_____ Date:_____

Family History (Please check if any blood relative {maternal/paternal} has experienced any of the following):

	Maternal	Paternal		Maternal	Paternal
Alcoholism	☐	☐	Diabetes	☐	☐
Anemia	☐	☐	Easy Bleeding	☐	☐
Anesthesia Complications	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Migraine Syndrome	☐	☐
Cancer	☐	☐			

Other notable family history: _____

Social History (please circle appropriate response):

Alcohol Use:	Never	Occasional	Daily
Tobacco Use:	Never	Previously but quit _____ years ago	Actively
Type of Tobacco:_____			
Recreational Drug Use:	Never	Occasional	Actively

Height:_____in. Weight: _____lbs.

Breast Cancer Screening (Women Ages 50-74): Last Mammogram Screening Date: _____

Colorectal Screening (Patients Ages 50-75):

Complete colonoscopy date: _____

Date suggested colonoscopy was last declined: _____

Pneumococcal Vaccination Status for Adults (Patients 65+): Vaccination Date: _____ Date Declined: _____

Influenza (Flu Shot) Immunization (all patients): Immunization Date: _____ Date Declined: _____

Review of Systems (please circle Y or N)

Constitutional			**Cardiovascular**			**Psychiatric**		
Fatigue	Y	N	Chest pain	Y	N	Anxiety	Y	N
Fevers	Y	N	Heart Palpitation	Y	N	Depression	Y	N
ENT			**Gastroenterology**			**Respiratory**		
Decreased Smell	Y	N	Constipation	Y	N	Chronic Cough	Y	N
Difficulty Swallowing	Y	N	Diarrhea	Y	N	Shortness of breath	Y	N
Nasal Obstruction	Y	N	Heartburn	Y	N			
Nose Bleeds	Y	N	Nausea	Y	N	**Hematology**		
Sinus Pain	Y	N				Easy bleeding	Y	N
Sinus Pressure	Y	N	**Eyes**			Easy bruising	Y	N
			Blurry Vision	Y	N			
Skin			Dry Eyes	Y	N	**Neurology**		
Rash	Y	N				Dizziness	Y	N
						Headaches	Y	N
Musculoskeletal			**Genitourinary**					
Weakness	Y	N	Burning urinations	Y	N			

Financial Policy

The Sparano Face and Nasal Institute is committed to providing the highest standard of care. In so doing, we aim to build secure and successful professional relationships with our patients. To do so, we feel it is important for you to understand our financial policy.

Insurance:

-You must provide proof of current insurance at every visit and update us with any demographic changes.
-You must provide a referral, if required by your insurance company, prior to your visit or otherwise pay cash.
-You are responsible for any co-pays, deductibles, and coinsurance as required by your insurance company at the time of service. A $10 processing fee will be added if the co-pay is not provided.
-Your insurance policy is a contract between you and your insurance company, therefore it is your responsibility to know your benefits.
-All fees generated are the responsibility of the patient.
-Insurance plan participation is subject to change.
-If we are not contracted with your insurance company, we do not accept their fee schedule as payment in full. Any balance is the patient's responsibility.

Diagnostic Endoscopy:

-Use of endoscopes is often important and necessary to appropriately diagnose sinonasal and other related conditions.
-Your insurance company may consider endoscopy a "surgical procedure" for billing purposes.
-The associated charge may be subject to additional deductible or coinsurance according to your surgical plan benefits.
-As with all healthcare services, you can decline endoscopy, but Dr. Sparano may feel it affords optimal diagnosis and/or treatment.

Fees:

Missed appointments require 24 hours prior notice. If proper notice is not given, the fees are as follows. These fees will automatically be charged to your credit card on file.

-Missed medical appointment $50
-Missed office procedure/Consultations $125

Returned check fee $25

Collection Agency:

All patient accounts that become 60 days delinquent may be sent to an outside collection agency, or attorney. This can result from possible discharge from the practice.

I have read and understand the terms and conditions set forth in the above policy. I understand that a duplicate copy of the financial policy is available for my reference upon request.

Print Name: _____

Signature: _____

Date: _____ / _____ / _____

Patient Privacy Form

I. Acknowledgement of Sparano Face and Nasal Institute Notice of HIPAA Privacy.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information/ I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice if Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ DOB: _____

Signature of Patient/Guardian: _____ Date: _____

II. Designation of relatives, friends, or other caregivers:

I agree that Sparano Face and Nasal Institute may disclose certain health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care. In that case, Sparano Face and Nasal Institute will disclose only information that is directly relevant to the person's involvement with my health care.

I wish to be contacted in the following manner (check all that apply):

Home telephone number: (_____) _____ - _____
_____ Acceptable to leave message with detailed information
_____ Leave message with call back number only
_____Acceptable to mail my home address as listed on the patient information form
_____ Acceptable to e-mail this address: _____

Work telephone number: (_____) _____ - _____
_____Acceptable to leave message with detailed information
_____Leave message with call back number only

I designate the persons listed below as persons involved with my healthcare, for the purpose of the practice making the limited disclosures as described above. I understand that I am not required to list anyone below. I also understand I may change this list anytime.

PLEASE NOTE: We will not release information to anyone who is not listed on this form.

Print Name: _____ DOB_____ _____
Your initials here

Print Name: _____ DOB_____ _____
Your initials here

Print Name: _____ DOB_____ _____
Your initials here

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for, patient health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/guardian. Healthcare entities must keep record of protected health information disclosures. Uses and disclosures for treatment, payment, and healthcare operations may be permitted without prior consent.

Signature: _____ Date: _____