COASTAL ENT ASSOCIATES PLLC
VINCENT PISCIOTTA, MD & CLAY BRATTON, MD

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Email		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female	
Marital Status:	Social Security #:		
Employer Name:	Driver's License #:	State:	
Emergency Contact Name:	Emergency Contact Phone #:	Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No

Race (please select):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Pharmacy Name & Location:

HOW DID YOU HEAR ABOUT US?

Google_____ **Other search engine**_____ **Facebook**_____ **Sinus Clear Website**_____ **Physician Referral**_____ **Friend/Family**_____ **Other**_____

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Coastal ENT Associates'(CENTA) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CENTA all money to which I am entitled for medical expenses related to the services performed from time to time by CENTA, but not to exceed my indebtedness to CENTA. I authorize CENTA to release any medical information to my insurance carrier or third- party payer to facilitate processing my insurance claims. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from CENTA by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to CENTA. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party X_____ Date_____

Printed Name of Responsible Party X_____ Date_____

Date: _____ Patient: _____

Referring Doctor: _____

Primary Care Doctor: _____

Pharmacy: _____ City: _____

ALLERGIES

Current Medications & Dosage

Surgical History

Procedure	Date	Procedure	Date

Tobacco Use	Alcohol Use
Never, quit, still smoke	Never, Occasionally, Daily
Number of packs per day?	Number of drinks per day?
Number of years smoked?	Type of alcohol?
Tobacco type?	

Medical History

Please check any conditions that are current or have occurred in the past.

☐ Cancer	☐ Stroke	☐ Liver Problems	☐ Heart attack
☐ Diabetes	☐ Hypertension	☐ Prostate Problems	☐ Blood Clots
☐ Asthma	☐ Glaucoma	☐ Stomach Ulcer	☐ Low Platelets
☐ Bronchitis	☐ Neuropathy	☐ Hepatitis	☐ Anemia
☐ Emphysema	☐ Eczema	☐ HIV (Aids)	☐ Leukemia
☐ Arthritis	☐ Eczema	☐ Hives	☐ Epilepsy
☐ Kidney Disease	☐ Lupus	☐ Heart murmur	☐ Tuberculosis
☐ High Cholesterol	☐ Heart Disease	☐ Other:	

Family History

Please note diseases or other medical conditions in relation to: Grandparents, Parents, Siblings.

Relationship:	Health Issue:

General:

Height: Weight Are you pregnant? Yes No	Occupation: Marital Status:

REVIEW OF SYSTEMS

(Please check any that currently apply)

GENERAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Persistent Infections
- ☐ Weight Gain > 10 lbs
- ☐ Weight Loss > 10 lbs

SKIN
- ☐ Bruising
- ☐ Hives
- ☐ Rash
- ☐ Psoriasis

NECK
- ☐ Swollen Glands

HEENT
- ☐ Glaucoma
- ☐ Visual Loss
- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Earache
- ☐ Nasal Obstruction
- ☐ Sneezing
- ☐ Nose Bleed
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Voice Change

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Black, Tarry Stool
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Jaundice

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Panic Attacks

NEUROLOGICAL
- ☐ Decreased Memory
- ☐ Headaches
- ☐ Seizures
- ☐ Stroke
- ☐ Tremor
- ☐ Vertigo

ENDOCRINE
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Excessive Urination

HEMATOLOGY
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising

REVIEW OF SYSTEMS (continued)

RESPIRATORY
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ History of Asthma

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Leg Cramps
- ☐ Muscle Atrophy
- ☐ Swelling of Extremities

MALE GENITOURINARY
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Frequency

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Stent
- ☐ Hypertension
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Slow Heart Rate
- ☐ Swelling of Extremities

BREAST
- ☐ Breast Mass
- ☐ Breast Pain

FEMALE GENITOURINARY
- ☐ Absence of Menstruation
- ☐ Blood in Urine
- ☐ Flank pain
- ☐ Frequency
- ☐ Hematuria
- ☐ Incontinence

☐ None of these symptoms currently exist

_____

Patient:

For Office Use Only _____

History and Present Illness: _____

_____

_____

_____

FINANCIAL POLICY

- Before each visit we encourage you to contact your insurance company's customer service department to discuss what is covered, to confirm your deductible and what your co-payment and/or co-insurance is for the office visits. This will ensure that you have an estimate of what your out-of-pocket cost will be.
- At the time of your appointment, we will collect your co-pay, deductible and/or co-insurance, and any outstanding balance due for services rendered. We accept cash, checks and credit cards for payment. **All credit card transactions will have a 3.25% processing fee.** All services are payable on the day the services are rendered.
- Insurance reimbursements can be a long and difficult process at times. Because of this, we only accept assignments for insurance companies with whom we are contracted. With these plans we have agreed to accept a discounted rate from the insurance company. However, all co-insurances, co-pays and deductibles are the responsibility of the patient/guarantor. We will estimate balances to the best of our ability by utilizing the information provided by your insurance company.
- Non-Contracted insurance plans may be billed as a courtesy. As a convenience and service to you, our office will absorb the cost of billing. However, we require payment in full from you at the time of service. Most secondary insurances will be filed as a courtesy provided the information is given. However, should the secondary insurance not pay within 30 days, the balance will be transferred to patient responsibility.
- Please note that your Primary Physician/Provider may provide services based on his or her professional judgement that may be deemed a "non-covered service" by your insurance company. Should you receive a "non-covered benefit" notice from your insurance company, please contact them for additional information. We will be happy to discuss the service and associated fees with you and/or your insurance company.
- Regardless of insurance coverage, the bill you receive is your responsibility. Any disputes are between the patient and the patient's insurance company. If there is a balance that cannot be paid in full within 30 days, it is the patient's responsibility to contact our office to make payment arrangements. Payment plans may be offered.
- In the case of default of payment on this account, interest may be charged to the account. The patient will be responsible for any legal interest, collections costs and reasonable attorney fees incurred to effectively collect the debt on this account.

I hereby authorize the listed insurance companies to pay directly to Coastal ENT Associates, PLLC benefits due as provided. I agree to pay all charges in excess of whatever sums may be applied. I authorize Coastal ENT Associate, PLLC to release information to the insurance company for my claims to be paid. I understand that regardless of insurance coverage, I am liable for the fees with deductible and cost shares being due on the date of service.

Should my balance require the action of collection efforts, I agree to pay up to 33% of the unpaid balance for collections costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection's agency. I further understand that in the event the account is referred to an attorney for collections, I agree to be liable for such additional reasonable court costs and attorney's fees and may be determined by a court. I hereby waive all rights to claim exemption of personal property and wages from execution, garnishment, or attachment pursuant to a lawful judgement otherwise granted to me under the laws and constitution of the state of Mississippi and the United States.

_____ _____

Responsible Party Signature Date

_____ _____

CENTA Representative Date

SINUS CLEAR

Sino-Nasal Outcome Test (SNOT-22) Questionnaire

Patient Name: _____

DOB: _____

Date: / /

Physician Staff will complete this section:

PT. ID.: _____

CT: Yes [ ] No [ ]

PrevFESS: Yes [ ] No [ ]

Chf. Complaint for Visit: _____

Do you have sinusitis? We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information.

A. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:

	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	Most important items
1. Need to blow nose	0	1	2	3	4	5	[ ]
2. Sneezing	0	1	2	3	4	5	[ ]
3. Runny nose	0	1	2	3	4	5	[ ]
4. Nasal obstruction	0	1	2	3	4	5	[ ]
5. Loss of smell or taste	0	1	2	3	4	5	[ ]
6. Cough	0	1	2	3	4	5	[ ]
7. Post-nasal discharge	0	1	2	3	4	5	[ ]
8. Thick nasal discharge	0	1	2	3	4	5	[ ]
9. Ear fullness	0	1	2	3	4	5	[ ]
10. Dizziness	0	1	2	3	4	5	[ ]
11. Ear pain	0	1	2	3	4	5	[ ]
12. Facial pain/pressure	0	1	2	3	4	5	[ ]
13. Difficulty falling asleep	0	1	2	3	4	5	[ ]
14. Waking up at night	0	1	2	3	4	5	[ ]
15. Lack of a good night's sleep	0	1	2	3	4	5	[ ]
16. Waking up tired	0	1	2	3	4	5	[ ]
17. Fatigue	0	1	2	3	4	5	[ ]
18. Reduced productivity	0	1	2	3	4	5	[ ]
19. Reduced concentration	0	1	2	3	4	5	[ ]
20. Frustrated/restless/irritable	0	1	2	3	4	5	[ ]
21. Sad	0	1	2	3	4	5	[ ]
22. Embarrassed	0	1	2	3	4	5	[ ]
TOTALS (each column):							

GRAND TOTAL SCORE (all columns together):

B. Please check off the most important items affecting your health in the last column (max of five items)

SINUS CLEAR

Name: _____ Date of Birth: _____

Phone: _____ Insurance: _____

Height: _____ Weight: _____

Last Sleep Study: _____

Have you been prescribed CPAP? (Check the appropriate box)

- ☐ YES using
- ☐ Tried, could not use
- ☐ Never prescribed

Do you snore loudly?

☐ Yes ☐ No

Are you currently being treated for high blood pressure?

☐ Yes ☐ No

Do you often feel sleepy during the day?

☐ Yes ☐ No

Has anyone observed you stop breathing during sleep?

☐ Yes ☐ No

Neck circumference > 16 inches?

☐ Yes ☐ No

"YES" to two or more indicates high risk for obstructive sleep apnea. A sleep study may be warranted. Please speak with your physician regarding your sleep disorder screening results.

SINUSCLEAR

DIZZINESS QUESTIONNAIRE

Patient Name:	Patient DOB:

1. When did your dizziness start or when did you start having episodes of dizziness?

   _____

2. Have you ever had any similar problems with dizziness in the past? ___Yes ___No

3. If so, when did they occur? _____

4. My dizziness is most accurately described as:
   - o Motion (feeling that you or the environment is swaying or unsteady)
   - o Spinning (sensation of rotation)
   - o Almost blacking or our loss of consciousness (fainting)
   - o Other: _____

5. My dizziness:
   - o Is constant
   - o Occurred only one time
   - o Comes in repeated attacks
   - o Other: _____

6. If dizziness occurs in attacks, how long does each attack last? In some cases there are several attacks or episodes over a period of time, for example, over a 2 week period you may have had one attack every day that lasted 20-40 minutes. Then the answer is 20-40 minutes. Just a rough range is fine.
   - o Very brief or seconds
   - o About 15 seconds to a minute
   - o A few minutes to maybe 20-40 minutes
   - o An hour to several hours
   - o 6-12 hours and sometimes longer
   - o Several days and/or months

7. If dizziness occurs in attacks, how frequently do they occur? Just a rough average will be fine.
   - o Many or several times a day
   - o Once each day
   - o Several times a week
   - o Once each week
   - o Several times each month
   - o Once each month
   - o Several times per year
   - o Less than once a year

8. If dizziness occurs in attacks, when was your last? _____

9. If it occurs in attacks, are you free of dizziness between attacks? ___Yes ___No

10. Do you have any of the following associated with dizziness or an attack dizziness?

- o Hearing loss
- o Increase in ear noises
- o Pressure or fullness in one or both ears
- o Nausea and/or vomiting
- o Ear pain or drainage
- o Sudden or rapidly progressive hearing loss
- o Double/Blurred vision or visual distortion
- o Temporary blindness
- o Facial Numbness
- o Facial weakness, paralysis, spasm
- o Extremity numbness
- o Extremity weakness
- o Poor coordination or clumsiness
- o Mental confusion
- o Loss of consciousness
- o Difficulty with speech
- o Difficulty swallowing
- o Prolonged tremor

11. Have you had any of the above NOT associated with dizziness? ___Yes ___No

12. Please describe an episode of dizziness in your own words or describe how you feel when you are dizzy. Try to use a word other than dizzy in your description, a word that is more precise such as spinning or faint, or a description of past experience that is familiar, for example, what occurred after you got office a ride at Disneyland, while riding on a boat, or when you got up too fast and almost passed out.

_____

_____

_____

13. Have you had any previous evaluation for dizziness? ___Yes ___No

14. Have you had any treatment for dizziness? ___Yes ___No

15. Have you had any scans for dizziness? ___Yes ___No

16. Have you had any lab tests for dizziness? ___Yes ___No

17. Have you had any hearing tests? ___Yes __No

SINUS CLEAR CENTA

Vincent J. Pisciotta, M.D.
Clay R. Bratton, M.D.

PRACTICE: Coastal Ear Nose & Throat
Dr. Clayton R. Bratton
Dr. Vincent J. Pisciotta
LOCATION: 2781 C. T. Switzer Sr. Drive Suite 400
Biloxi, MS 39531
PRIVACY OFFICIAL: Lisa Barfield
PHONE: 228-388-4585

NOTICE OF PRIVACY PRACTICE RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print name of patient: _____

Signature of Patient or Responsible Party:

_____

Date: _____

Patient's Date of Birth: _____

Please put the name of the Personal Representative of the patient. This would be a guardian for a child, or anyone you would wish to be able to discuss something to do with the patient here at our office. If the person or persons name is not on this paper we **CAN NOT** discuss any business concerning patient.

Print name of Person Representative: _____

Relationship to patient: _____

Second Personal Representative: _____

Relationship to patient: _____

Signature of Employee: _____ Date: _____

CENTA
Coastal Ear, Nose, and Throat Associates

Vincent J. Pisciotta, M.D.
Clay R. Bratton, M.D.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
REQUEST FOR MEDICAL RECORDS

I hereby authorize _____ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Dr. Vincent J. Pisciotta

Dr. Clay R. Bratton

Patient Name:_____ DOB:_____

Patient SSN:_____

Patient Address:_____

Disclose the following PHI for treatment dates:_____ to _____.

_____Abstract/Pertinant	_____History & Physical	_____Discharge Summary
_____Operative Report	_____Progress Notes	_____Physician Orders
_____ER Report	_____Lab	_____X-Ray
_____Consult	_____Nurse Notes	_____Entire Chart

Other Specified:_____

The above information is disclosed for the following purposes:

_____Medical Care _____Legal _____Personal _____Other

_____I acknowledge, and hereby consent to such, that the released information may contain
(Initials) Alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall expire upon this date:_____
***If I fail to specify an expiration date or event, this authorization will expire six(6) months from the date of which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the healthcare provider. I understand that revocation will not apply to the information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorized the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Witness If signed by legal rep. Relationship

* Please fax to 228.385.7010