PATIENT REGISTRATION FORM
John R. Gilmore, M.D.

Patient Information

Patient's Name_____ Date Of Birth ___/___/___ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security _____ - _____ - _____

Marital Status: Single / Married / Widowed / Divorced Email Address: _____

Patient's Employer _____ Occupation _____

Address _____ Phone _____

Emergency Contact _____ Phone _____

Billing and Insurance

Primary Health Insurance	Secondary Health Insurance
Insurance Name _____	Insurance Name _____
Claims Address _____	Claims Address _____
_____	_____
Phone _____	Phone _____
Policy/ID # _____	Policy/ID # _____
Group # _____	Group # _____
Insured's Social Security _____	Insured's Social Security _____
Name Of Insured _____	Name Of Insured _____
Insured's Date Of Birth _____	Insured's Date Of Birth _____

Responsible Party For This Bill? _____

Referring Doctor Information

Name Of Primary Care Physician _____ Phone _____

Address _____ City/State _____ Phone _____

Pharmacy Name: _____ Phone _____

Referring Doctor: _____ Phone _____

Patient Signature: _____ Date _____

JOHN R. GILMORE, M.D.

HIPAA/PATIENT CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Name _____

Date of Birth _____ Social Security # _____

I understand that as part of my healthcare, Dr. Gilmore originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Dr. Gilmore's Notice *of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the Dr. Gilmore reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Dr. Gilmore is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Dr. Gilmore has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Dr. Gilmore's *Notice of Privacy Practices* dated April 14, 2003.

_____
Signature of Patient or Legal Representative, Date

_____
Print Name of Patient or Legal Representative

_____
Witness, Date

_____
Print Name of Witness

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address: _____

_____

Office Use Only:
□ Accepted
□ Denied

_____ _____ _____
Signature Title Date

Insurance and Payment Policy Information for John R. Gilmore, M.D.

We are committed to providing you with the best possible care. If you have medical insurance, we will be happy to file your insurance for you and help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, checks, money orders,Visa, Mastercard and Discover.

We will glady discuss your proposed treatment and answer any questions relating to your insurance. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. Not all services are a covered benefit. We are a Medicare provider. This means that we have a contract with Medicare to accept their fee schedule for reimbursement for services rendered. You are responsible for any deductible portion not me tand any co-insurance amounts. Supplies are not a covered benefit and will be due at the time of service.

We realize that financial hardship may affect timely payment of your account. Please contact us promptly for assistance in the management of your account if you need payment arrangements. We turn all accounts over 90 days past due to our Collection Service. In the event that your account is turned over to the Collection Service, you will be responsible for the commission percentage that is charged to us.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Appointment Cancellation Policy:

Patients will be charged a $25.00 cancellation fee for not canceling an appointment within 24 hours of their scheduled appointment. Patients will be dropped from the practice if this becomes a perpetual problem.

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Signature of Patient or Legal Representative, Date	Witness, Date
Print Name of Patient or Legal Representative	Print Name of Witness

JOHN R. GILMORE, M.D.

Patient Preference Regarding Communication of Health Information

Patient Name: _____ Patient Identifier #: _____

Who to Contact

I hereby grant permission to Dr. John R. Gilmore, M.D. to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

How to Contact- We do not respond by E-Mail. This is not HIPPA compliant

I wish to be contacted in the following manner:

Telephone:

Home/Work/Cell Telephone: (Please check)
____ OK to leave a message with detailed information
____ OK to leave message with call back number

Written Communication:

____ OK to mail to my home address _____

____ OK to mail to my work/office address _____

____ OK to Fax to this number _____

The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature

_____

_____ **I DO NOT WISH TO GIVE PERMISSION FOR FAMILY MEMBERS, RELATIVES OR CLOSE PERSONAL FRIENDS TO HAVE ACCESS TO ANY INFORMATION REGARDING MY MEDICAL CONDITION.**

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature

Patient Name: _____

REVIEW OF SYSTEMS Please circle the symptom or disease if you have experienced it within the PAST YEAR:

Constitutional Fatigue fever weight loss (_____lbs.) weight gain (_____lb.)

Eyes itching burning eye pain

Ears difficulty hearing ear pain vertigo tinnitus
Ears feel pressured discharge from the ears

Nose frequent nosebleeds nasal congestion nose/sinus problems
rhinorrhea sinus pressure blockage/obstruction

Mouth/Throat sore throat bleeding gums snoring dry mouth
oral abnormalities mouth ulcer teeth abnormalities difficulty swallowing
post nasal drip hoarseness mouth breathing

Neurologic
Neuro: Fainting frequent headaches seizures numbness weakness migraines
Restless legs

Neurologic: loss of consciousness weakness

Cardiovascular
Cardio: Chest pain h/o murmur dyspnea on extertion palpitations edema
Light-headed on standing

Respiratory
Lung: Wheezing shortness of breath hemoptysis sputum production sleep apnea

***Gastrointestinal*:**
Vomiting heartburn painful swallowing no appetite increased appetite

Hematologic/Lymphatic
Lymph: swollen glands easy bruising excessive bleeding

Psychiatric
Psych: depression anxiety restless sleep

Musculoskeletal
Musculoskeletal: muscle aches joint pain/arthralgias

Integumentary

Skin: rash itching dry skin growths/lesions

Endocrine

Endocrine: increased thirst increased drinking increased hunger

Allergic/Immunologic

Allergy/Immunologic: frequent sneezing runny nose

Other

Other: Pregnant

Genitourinary

Genitourinary: difficulty urination pain during urination urinary retention urinary loss of control increased urinary frequency hematuria

Sino-Nasal Outcome Test (SNOT-22) Questionnaire

Patient Name: _____

DOB: _____

Date: / /

Dr. Gilmore's staff will complete this section:

PT. ID.: _____

Asked Pt. About Appt. expectations? Yes [ ] No [ ]

CT: Yes [ ] No [ ] Recommended [ ]

Medication: Prescribed [ ] Failed [ ] Refused [ ]

Did Pt. Have a Prior Sinus Procedure? Yes [ ] No [ ]

Is a Sinus Procedure Recommended? Yes [ ] No [ ]

->if yes, scheduled? Yes [ ] No [ ]

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)