Jorge J. Arango M.D., PLLC
5959 Gateway Blvd. West Suite 104
El Paso, Texas 79925
Ph: (915) 351-5023
Fax: (915) 351-5024
Email: frontdesk@jarangomd.com

Patient Information

Today's date: _____ Social Security #:_____

Patient's first/last name: _____

Date of birth: _____ Marital Status: [ ] Minor [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Current mailing address: _____

City: _____State:_____ZIP code: _____

Cell Phone #:_____Home Phone #:_____

Email address: _____

Emergency contact: _____Phone #:_____

Preferred Pharmacy: _____Location:_____

Referring Physician_____

Primary Care Physician: _____

Insurance Information

Primary insurance: _____

Patient's relation to primary policy holder: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

Policy Holder's name: _____Policy holder's Date of Birth: _____

Secondary insurance: _____

Patient's relation to policy holder: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

Policy Holder's name: _____Policy holder's Date of Birth: _____

Tertiary insurance name (if applicable):_____

Insurance Assignment and Release

I, the undersigned certify (or my dependent) have insurance coverage with_____and assign directly to Dr. Jorge J Arango all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____

Patient/or guardian signature Date

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Authorization for Use, Release and Disclosure of Protected Health Information

Patient's Legal Name:_____

Date of birth: _____

Social Security number:_____

Telephone number:_____

Address_____City:_____State:_____ZIP:_____

I hereby authorize Dr. Jorge J Arango to disclose and request medical records information and/or protected information of the patient listed above to:

Insurance (including disability insurance), health department, pharmacies, hospitals, employers, referring doctors, and consulting doctors for treatment purposes only.

Types of Access Requested

Copies of record	Abstract/pertinent	Progress notes
Inspection of record	Consult report	Physician orders
Operative report	Medication record	Lab orders
Entire record	Other	

_____I acknowledge and hereby consent to such, that the release information may contain alcohol, drug abuse, mental health, AIDS/HIV results, diagnosis and related information.

Expiration: This authorization shall expire in <u>one year</u>.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon or if authorization was obtained as a condition of insurance coverage. To revoke this authorization written notice must be submitted to Dr. Jorge J Arango.

The information used to disclose pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. Fee/charges will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure/release of my protected health information.

X_____ _____

Patient/Guardian Signature **Date**

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Statement of Confidentiality and Privacy Notice Acknowledgement

It is the office policy of Jorge J Arango M.D. PLLC. and staff not to release confidential and or unauthorized information by home telephone, answering machine, work telephone, voicemail, cell phone and/or email. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I give permission to be contacted by the following methods:

Cell Phone/ Voice mail [ ] YES [ ] NO Phone #: _____

Email Address: [ ] YES [ ] NO Email:_____

If you would like information released to someone **other than yourself**, please complete the following:

List of authorized people:

_____ _____

_____ _____

I hereby acknowledge that I have been given the opportunity to read and review the Notice of Privacy Practices, located on the provider's website. I understand that a copy of this notice will be made available to me, for my personal use, **if requested**.

_____ _____

Patient's Name (Please Print) Date of Birth

FOR STAFF USE ONLY

Good faith effort has been made to obtain a written acknowledgement of the Notice of Privacy Practices made available to the patient. An acknowledgement has not been obtained because:

☐ Patient refused to sign the acknowledgement despite having opportunity to read and review.
☐ Other: Patient was unable to sign the acknowledgement because:_____

X_____
Employee signature

X_____ _____

Patient/ Guardian Signature **Date**

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Office Policies

Insurances:

• Please be familiar with your insurance plan requirements before seeing your doctor.

• Please make certain you know whether your insurance plan requires that you obtain a referral and an authorization from your primary physician prior to seeing your specialist.

• Please know your individual plan requirements for payment to Dr. Jorge J. Arango or hospital, including co-payments and deductibles.

Please understand that services not paid by your plan due to failure to comply as a patient, will be your responsibility to pay according to your insurance policy.

Co-payments, deductibles, co-insurance are to be collected before services are rendered. We accept cash, checks, money order, Visa, MasterCard, Discover, and American Express & Care Credit. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility /non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. **We will need to reschedule your appointment if past due balances are not paid in full prior to your follow up/next appointment. **Past due amounts must be paid before non-emergency care is provided**. *If you are a Medicare beneficiary, Medicare will be billed for you. You will be responsible for deductibles, all non-covered services etc. according to Medicare guidelines.

Referral Policy

❖ I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. **Failure to do so will result in charges being billed directly to myself or cancellation of my appointment until I can obtain one.**

Insurance Card & I.D. Policy

❖ If you do not bring a valid insurance card & valid state, federal I.D., or passport the day of your visit you will be rescheduled. It is the patient's responsibility to provide Jorge J. Arango M.D. PLLC. With all their current insurance information. Withholding insurance information relevant to the process insurance claims to the correct agencies, may constitute as fraudulent acts and may be punishable by law.

Form Policy

❖There is a **$30.00 fee** for all forms filled out in our office. Forms including insurances, disability, and maternity leave and any other medical forms. It may take up to **2 weeks for forms to be filled out**. Payment is due at the time the papers are dropped off. Forms will not be accepted without payment.

Surgery Deposit Policy

❖ There will be a **$100 deposit required to schedule your surgery**. This $100 will be applied to patient responsibility and/or patient balance.$100 will be refunded after insurance pays for services rendered. If surgery is not cancelled within 7 days of scheduled date $100 deposit will be **NON REFUNDABLE.**

I HAVE READ, UNDERSTOOD & AGREE TO ABIDE BY THE ABOVE, PAYMENT, INSURANCE AND OTHER OFFICE POLICIES.

X_____ _____

Patient/Guardian Signature **Date**

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MEDICATIONS

Name:	Dosage:	Frequency:

MEDICATION ALLERGIES

Name:	Reaction caused:

SURGERIES IN THE PAST 5 YEARS

Name:	Date:

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Social History

Smoke YES NO

Former Smoker YES NO → Total Years smoking: _____

Drink Alcohol YES NO → How often? _____

Any drug use YES NO → If yes, type: _____

Caffeine intake YES NO → How often? _____

Exercise YES NO → How often? _____

Driving Status YES NO → Please Check: Day_____ Night_____

Occupation:_____

Family Medical History

	YES	NO
History of Cancer		
Diabetes		
Heart Disease		
Hypertension (High Blood Pressure)		
Hypercholesterolemia (elevated cholesterol)		
Osteoporosis		
Stroke		
Thyroid Issues		

Quality Measures

Please complete if over the age of 65.

Have you received your pneumonia vaccination? YES NO

In the event that you cannot make your own medical decisions, do you have a health care proxy? YES NO

If so,

Name:_____ Ph #:_____

Do you have a living will? YES NO

IN CASE OF AN EMERGENCY AND/OR FOR OUR RECORD IN CASE OF SCHEDULED SURGERY

Which statement best represents your wishes on advance care recommendations? *(Please check one)*

- o Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life
- o Do not resuscitate: If my heart were to stop, I do not wish to have chest compressions or a AED to restart my heart, even if it is necessary to save my life
- o I want Full Cardiopulmonary Resuscitation to be made.

Signature: _____

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PLEASE COMPLETE FORM IF YOUR REASON FOR THE VISIT IS FOR SINUS ISSUES AND/OR ALLERGIES; OTHERWISE PLEASE SKIP

Patient name: _____ **D.O.B.:** _____

- The following questionnaire is intended to help define your symptoms and provide valuable information about your health for your doctor. Please answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

- Consider 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.	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem As Bad As It Can Get
Need to blow nose?	0	1	2	3	4	5
Sneezing?	0	1	2	3	4	5
Runny Nose?	0	1	2	3	4	5
Cough?	0	1	2	3	4	5
Post-Nasal Discharge?	0	1	2	3	4	5
Thick Nasal Discharge?	0	1	2	3	4	5
Ear Fullness?	0	1	2	3	4	5
Dizziness?	0	1	2	3	4	5
Ear Pain	0	1	2	3	4	5
Facial Pain / Pressure?	0	1	2	3	4	5
Itchy Nose?	0	1	2	3	4	5
Itchy Eyes?	0	1	2	3	4	5
Tearing?	0	1	2	3	4	5
Difficulty Falling Asleep?	0	1	2	3	4	5
Wake Up at Night?	0	1	2	3	4	5
Lack of Sleep?	0	1	2	3	4	5
Wake Up Tired?	0	1	2	3	4	5
Fatigue?	0	1	2	3	4	5
Reduced Productivity?	0	1	2	3	4	5
Reduced Concentration?	0	1	2	3	4	5
Frustrated / Restless / Irritable?	0	1	2	3	4	5
Sad?	0	1	2	3	4	5
Embarrassed?	0	1	2	3	4	5

Would you like to be allergy tested? YES: _____ NO: _____ TOTAL: _____

X_____

Patient/Guardian Signature

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Medical History

Please select any of your past/current medical problems if applicable.

- ☐ Asthma
- ☐ Diabetes Mellitus
- ☐ Hepatitis
- ☐ HIV
- ☐ High cholesterol
- ☐ Hyper coagulation Syndrome
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ Previous Blood Transfusions
- ☐ Tuberculosis
- ☐ GERD/Acid Reflux
- ☐ Otosclerosis
- ☐ **Other:**

ENT Disease History

- ☐ Deviated Nasal septum
- ☐ Disorder of the ear
- ☐ Disorder of the nose
- ☐ Epistaxis (Nose Bleeds)
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Sleep Apnea
  - Do you use a CPAP machine?
    [ ] YES [ ] NO
- ☐ Vertigo
- ☐ Vocal Cord Paralysis
- ☐ Vocal cord polyps

Review of systems (PLEASE SELECT ANY CURRENT SYMPTOMS)

- ☐ Bleeding
- ☐ Dizziness
- ☐ Dry mouth
- ☐ Difficulty swallowing
- ☐ Change in voice
- ☐ Itching ears
- ☐ Foul smell
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Loss of smell
- ☐ Nasal obstruction
- ☐ Pain when swallowing
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Post nasal drip (PND)
- ☐ Nasal drainage
- ☐ Throat pain
- ☐ Tinnitus
- ☐ Ulcers
- ☐ Neck pain
- ☐ Neck mass
- ☐ Increased infections
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Fever
- ☐ Aches and pain
- ☐ Dry hair
- ☐ Dry skin
- ☐ Blurry vision
- ☐ Excessive tears
- ☐ Eye pain
- ☐ Vision loss
- ☐ Early satiety
- ☐ Heartburn
- ☐ Vomiting
- ☐ Increased bleeding
- ☐ Blisters
- ☐ Rash
- ☐ Swelling
- ☐ Confusion
- ☐ Anxiety
- ☐ Depression
- ☐ Cough
- ☐ Excessive saliva