CARL D. COPPOLA, M.D., F.A.C.S., P.S.C.

OTOLARYNGOLOGY HEAD & NECK SURGERY

BAPTIST EAST DOCTORS BLDG.
3950 KRESGE WAY #402
LOUISVILLE, KY 40207
502-893-3683
502-893-1662 FAX

Items you will need at the time of your appointment along with the new patient forms filled out are as follows:

1. Insurance cards
2. Driver's license
3. Pharmacy name, address and phone number
4. Test results regarding your problem such a CT scans, MRI/MRA, thyroid ultrasound, labs, etc.
5. List of medications and dosages

Patient Information

First name: _____ Last name: _____ MI: _____

Sex: Male Female Date of Birth: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Home or Cell? _____

Secondary Phone: _____ Home or Cell? _____

Work Phone: _____ Employer: _____ Occupation: _____

Family/Primary Care Physician: _____ Referring Dr: _____

Pharmacy: _____ **Location:** _____ Mail Order: _____

Marital Status: **Ethnicity:** **Status:**

- o Single
- o Married
- o Widowed
- o Divorced

___ American Indian or Alaskan Native
___ Asian
___ African American/Black
___ Native Hawaiian/Pacific Islander
___ White/Caucasian
___ No Comment

___ Student
___ Full Time
___ Part Time
___ Retired
Other_____

Emergency Contact

Name: _____

Relationship: _____ Phone: _____

Insurance

Name of Insurance: _____ Are you the primary subscriber? __Yes __No

If no, Name of Subscriber: _____ Relationship to Patient: _____

Their Date of Birth: _____ Their SSN: _____

Subscriber Address: _____

Authorization for Use and Disclosure of Protected Health Information

List the names of persons to whom health information may be disclosed:

_____

How did you learn about our office? _____

Signature: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

MEDICAL CONDITIONS (diabetes, high blood pressure, heart, lung, kidney, or liver disease, cancer, arthritis, asthma, stroke, etc.)

_____

_____

HOSPITALIZATIONS (illnesses, surgery, etc.-including dates)

_____

_____

MEDICATIONS (include dosage and frequency-if you have a list, record that information here)

_____

_____

_____

Do you smoke? YES ___ NO___ **Have you ever smoked?** YES____ NO_____
If so, how much? _____ **When did you quit?** _____
Do you use alcohol? YES_____ NO_____ **If so, how much?**_____

DRUG ALLERGIES _____

Please list types of reactions (*rash, throat swelling, nausea/vomiting* etc)

_____

Are you ALLERGIC to *LATEX?* YES_____ NO_____

FAMILY MEDICAL HISTORY (asthma, allergies,cancer , bleeding thyroid disorders, hearing loss, etc—list relative & condition

_____

_____

Please give any other insights that might help in understanding the reason for today's visit:

_____

_____

Are there any changes in insurance, address, or phone? YES NO

If yes, please list changes:_____

HIPAA: I have read and agree to the HIPAA information provided by Dr Coppola.

Assignment of Insurance Benefits: I authorize direct payment or surgical/medical benefits to Dr. Coppola for services rendered by Dr. Coppola in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Medical Information : I authorize Dr. Coppola to release any medical or incidental information or request medical records that may be necessary for either medical continuity of care or in processing applications for financial benefits or government required programs.

Consent for Release of Prescription History: I have read and agree to Release of Prescription History provided by Dr. Coppola.

Missed Appointments/Non-sufficient Funds: I understand that there may be a fee for appointments not cancelled with 24 hours notice and/or checks returned for insufficient funds.

Email address: _____

Signature:_____

Date of Birth:_____

Date:_____

Telephone (502) 893-3683
Fax (502) 893-1662

CARL D. COPPOLA, M.D., F.A.C.S.
DISEASES OF THE EAR, NOSE & THROAT

Office Hours
By Appointment

SUITE 402
BAPTIST EAST DOCTORS BUILDING
3950 KRESGE WAY
LOUISVILLE, KENTUCKY 40207

Patient Notification for Payer Payment Policies for Certain In-Office Procedures

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment of an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

Flexible Laryngoscopy: This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Nasal Endoscopy: The procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal Endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue.

Office medical supplies for insertion of ear tube(s).

1 tube = $40
2 tubes = $70

**__We do not file insurance claims for this medical supply charge.__

Please speak with our staff or clinical assistants if you have any questions.

_____
Patient Signature

_____
Date