Mike S. Shin, M.D.
Ear, Nose, and Throat
Facial Plastic and Cosmetic Surgery

Patient Information

Date _____

Last _____ First _____ Middle Initial _____
Street Address _____ _____ _____ _____
City State Zip
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ _____
Cell Phone Carrier
Email address_____@_____

Date of Birth _____/_____/_____ Age _____ Gender: _____
Marital Status: S / M / D / W Language Preference _____
Race _____ Ethnicity _____
Social Security Number _____

Occupation _____ Work Phone (_____) _____-_____ Employer Name _____
Employer Address _____ _____ _____ _____
City State Zip
Emergency Contact Name _____ (_____) _____- _____
Phone Number
Referring Doctor _____ Primary Care Physician _____

Guarantor Information (Person responsible for payment of the account)

Responsible Party Name _____ Date of Birth _____/_____/_____
Social Security Number _____ Relation to Patient _____

Street Address _____ _____ _____ _____
City State Zip
Home Phone (_____) _____- _____ Cell Phone (_____) _____- _____ Marital Status _____
Employer Name _____

Employer Address _____ _____ _____ _____
City State Zip

Insurance Information

PRIMARY INSURANCE
Name of Subscriber _____ Date of Birth _____/_____/_____
SSN _____ Relationship to Patient _____
Subscriber's ID# _____ Group Number _____
Insurance Name _____ Employer _____

SECONDARY INSURANCE
Name of Subscriber _____ Date of Birth _____/_____/_____
SSN _____ Relationship to Patient _____
Subscriber's ID# _____ Group Number _____
Insurance Name _____ Employer _____

Worker's Compensation

Name _____ Date of Birth _____/_____/_____
Date of Injury _____/_____/_____ Employer _____
Worker's Comp Insurance Carrier _____ Insurance Address _____
Claim Number _____ SSN _____
Adjustor's Name _____ Adjuster Phone Number (_____) _____- _____

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PATIENT MEDICAL HISTORY

Patient Name_____ DOB_____

Allergies to medications_____

Pharmacy_____Phone_____

Pharmacy Address/Major Cross Streets_____City_____

What medications are you taking that are prescribed or over the counter?_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Immunization Record Up To Date?.....Yes…….No Copy of Immunizations on File?.....Yes…….No

Do you ☐ Have metal in the body ☐ Have Pacemaker ☐ Problems with anesthesia

☐ Smoke ☐ Drink alcoholic beverages

List major surgeries with dates:

Date of Surgery	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you pregnant or do you think you're pregnant? Yes No

Are you nursing? Yes No

What other types of doctors or health care providers have you seen for this condition?_____

_____

Preference of diagnostic testing facility_____

Patient Recent Illnesses (please circle)

Growth in Nose	Fever or Chills	Depression
Nose Blockage	Skin Rash	Snoring
Nose Bleeding	Headaches	Bloody Sputum
Nose Drainage	Dizziness	Chest Pain
Ringing in Ears	Facial Pain	Ankle Swelling
Ear Pain	Hoarseness	Weight Loss of 10lbs or more
Ear Drainage	Heartburn	Fainting or Convulsions
Loss of Hearing	Sore Throat	Nausea or Vomiting
Painful Eyes	Sore Mouth	Difficulty Swallowing
Eyes Watering	Growth in Mouth	Shortness of Breath
Eyes Itching	Lump on Neck	Cough or Wheezing
Sneezing	Sore Neck	Trouble Seeing

Patient Medical History (please circle)

Cancer	Nose Polyps	Hepatitis or AIDS
Hypertension	Angina	Hearing Loss
Thyroid Disease	Alcohol Use	Tobacco Use
Stroke	Tuberculosis	Asthma/ Emphysema
High Cholesterol	Allergies	Latex Allergy
Heart Attack	Ulcers/ Reflux	Diabetes
Endocarditis	Anemia	Bleeding Disorder
Sinusitis	Blood Transfusion	

Immediate Family Medical History (please circle and write next to illness the family member)

Cancer	Nose Polyps	Hepatitis or AIDS
Hypertension	Angina	Hearing Loss
Thyroid Disease	Alcohol Use	Tobacco Use
Stroke	Tuberculosis	Asthma/ Emphysema
High Cholesterol	Allergies	Latex Allergy
Heart Attack	Ulcers/ Reflux	Diabetes
Endocarditis	Anemia	Bleeding Disorder
Sinusitis	Blood Transfusion	

Mike S. Shin, M.D.

MIKE S. SHIN, MD FINANCIAL & OFFICE POLICIES AGREEMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial and office policies. If you have any questions about the form, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibility as an essential element of your care and treatment.

Your signature below forms a binding agreement between Mike S. Shin, MD, Inc, the provider of medical services, and the patient who is receiving medical services, or the responsible party for minor patients (those who are under 18 years old). Responsible party is the individual who is financially responsible for payment of medical bills.

NO SHOW AND CANCELLATION POLICY

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to cancel or reschedule your appointment. There is a no show, late cancellation or reschedule fee if you do not cancel or reschedule your appointment before 24 hours of your appointment. The fee is $50.00 for office visits, and $100.00 for office procedures, or hearing test (audio test). The fee is $300.00 for surgery.

FORMS AND MEDICAL RECORDS POLICY

There will be a $25.00 form fee for each FMLA form, insurance form, and for medical records.

COPAY AND BALANCE POLICY

Pay any required copay at the time of visit.

A written agreement must be made between the manager and the responsible party. This is required for any payment arrangements made. The entire balance is due upon receipt of the statement.

NON-PAYMENT ON ACCOUNT POLICY

For any collections proceedings or other legal actions that become necessary to collect an overdue account, the patient or patient's responsible party understand that Dr Mike S. Shin has the right to disclose Kings Credit Services all relevant personal and account information necessary to collect payment for services rendered. Once an account has been placed in our collection agency, there will be an additional $25.00 late charged added to your account, and you will need to find another physician to take over your care.

RETURNED CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), it is the patient's or patient guardian's responsibility for the original check amount in addition to a $25.00 service charge. We will send you a letter to notify the responsible party of the returned check. If there is no response within 10 days from the letter date, the account will be turned over to our collection agency and a late charge of $25.00 will be added to the outstanding balance, and an additional $25.00 check service charge.

INSURANCE POLICY

As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words, you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within the reasonable length of time (within 45 days), you may be responsible for the account balance. If you fail to notify us of any change in insurance, you are fully responsible for any amount not paid by your insurance company.

FINANCIAL AGREEMENT

I hereby authorize Mike S. Shin, M.D. to furnish my insurance company with all the information which they request concerning my present illness or injury. I request that payment of authorized benefits be made on my behalf for services provided to me by the party which accepts assignment. I understand that I am financially responsible to make prompt payments to the account of Mike S. Shin, M.D. as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection, I shall pay the actual attorney's fees and collection expenses. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that failure to make payment for any services not covered will result in my account being sent to Kings Credit Services.

NOTICE OF PRIVACY POLICIES

I have been presented and given a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the notice, and subject to the following restriction(s) concerning my personal medical information. I agree to the disclosures named in the Notice: Notice of Privacy Practices of Mike S. Shin, M.D.

I understand and agreed by Mike S. Shin office policies and wish to continue care.

Patient Printed Name_____

Patient/ Guardian Signature_____ Date_____

Witness Signature_____ Date_____