

Leonard V. Covello, M.D.
Facial Plastic and Reconstructive Surgery
Otolaryngology – Head and Neck Surgery

900 Ridge Road, Suite E
Munster, IN 46321

(219) 836-8100
Fax (219) 836-9656

RE: Ear, Nose, Throat Exam and/or
Facial Plastic & Reconstruction Exam

To Our New Patient:

Thank you for scheduling an appointment with Dr. Covello. An appointment has been scheduled for you on _____ at _____ A.M. / P.M.

Enclosed are three forms that will need to be completed and brought with you to this appointment. Along with these forms, please bring your insurance cards, and a license with current address/photo I.D. Also, please bring any CT films, MRI reports, hearing tests or other reports that would help in your diagnosis. **Copayments and deductibles are due at the time of your appointment.** Our office accepts cash, check or credit cards (Master Card, Visa and Discover).

As of October 3, 2006, we no longer accept Medicaid as a primary, secondary, or tertiary insurance. We are notifying you of this to make you aware that you will be responsible for any balances that would have been covered by Medicaid.

If you should have any questions, please contact our office at (219) 836-8100.

Sincerely,

Beth Roche
Office Manager

VISIT OUR WEBSITE AT WWW.COVELLOSINUSCENTER.COM

MEDICAL HISTORY (Adult)

Please describe the reason for your visit: _____

Please list all drug related allergies or intolerances: _____

Please list all medications you are currently taking (including over-the-counter medicines, aspirin, birth control pills, vitamins) along with the dosage: _____

Do you have a history of (check all that apply):

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nasal Allergy | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> TIA's |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stuffy Nose | |
| <input type="checkbox"/> Positive HIV/AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | |

Any other major illness not listed above: _____

Have you ever suspected exposure to HIV?	YES	NO	Do you wear contact lenses?	YES	NO
Have you had any reaction to anesthetics?	YES	NO	Do you wear glasses?	YES	NO
Have you ever seen a psychiatrist?	YES	NO	Do you wear hearing aids?	YES	NO
Have you ever had a blood transfusion?	YES	NO	Do you bruise or bleed easily?	YES	NO

Is there a family history of (check all that apply):

- | | | | | |
|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anesthetic Reactions | <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital Defects | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | |

Do you smoke cigarettes/tobacco products? YES NO If yes, how many packs/day? _____ Years? _____

Do you now or did you ever drink alcohol? YES NO If Yes, 1 -3 drinks per day or 4+ drinks per day

Please list all previous operations and hospitalizations you have had, along with approximate dates:

Who is your primary care physician? _____

Do we have permission to contact your physician? YES NO Phone # _____

By signing below, I agree that the above information above is complete and correct to the best of my knowledge.

Patient's Signature

Date

Patient's Name: _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Leonard V. Covello, M.D. 900 Ridge Road Suite E, Munster, IN 46321

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy and payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize office staff to make reminder calls and leave medical messages as needed.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

I understand that Dr. Covello's office reserves the right to charge interest or a said fee on delinquent accounts. Also, a late fee of \$25.00 may be placed on budget accounts that are not paid on a monthly basis.

I further understand that it is my responsibility to give 24 hours notice of a cancelled appointment. A fee of \$45.00 will be charged for failure to give notice of cancellation of an appointment.

Date _____

Signature of policy holder _____

Signature of claimant, if other than policy holder _____