

SW EAR & Sinus Center
DR. Terrance Kwiatkowski

phone (702)966-3100 | 10410 S Eastern Ave, Suite 100, Henderson, NV 89052

Patient's Last Name _____ First Name _____ Middle Initial _____
SSN _____ - _____ - _____ Date of Birth ____/____/____ Age _____ Sex: F M Non-disclosed
Address _____ Apt.# _____ City _____ State _____ Zip _____
Day Phone: (____) _____ Cell Phone: (____) _____
E-mail Address: _____
Employed By _____ Occupation _____
Business Address: _____ Business Phone (____) _____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR INSURANCE, PLEASE COMPLETE THIS SECTION

Guardian/Spouse Full Name: _____ Phone: (____) _____

Primary Care (Family) Physician / Pediatrician _____

Address _____ Phone: (____) _____

Referred By: _____ Phone: (____) _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE _____

SSN _____ Policy Holder DOB _____ Policy Holder _____

Patient's Policy # _____ Group Name (if applicable) _____

SECONDARY MEDICAL INSURANCE _____

SSN _____ Policy Holder DOB _____ Policy Holder _____

Patient's Policy # _____ Group Name (if applicable) _____

Person In Case Of Emergency: _____ **Phone:** (____) _____

Pharmacy _____ **Cross Streets** _____ **Phone:** (____) _____

I authorize SW Ear & Sinus Center, practice of Terrance Kwiatkowski, MD to release information related to this treatment / bill for services to my insurance company, health care companies for my treatment, and/or any information needed for my medical claim(s). I authorize direct payment to Terrance Kwiatkowski, MD, PC for my medical services. I understand that I am financially responsible for charges not covered by my insurance plan/company. I authorize SW Ear & Sinus Center, practice of Terrance Kwiatkowski, MD to release my medical records to my family physician, referring physician and current treatment physician. I understand that these records may be sent via electronic channels. I agree that the above information is true and correct to the best of my knowledge and agree to the statements above.

Signature of Patient or Authorized Person to Consent _____

Printed Name _____ Date _____

MEDICAL HISTORY FORM Page 1

Patient Name: _____ DOB: ____/____/____ Todays Date: ____/____/____

Primary complaint for today's visit? _____ When did it begin? _____

When is the problem worse (with activities, weather, position)? _____

When is the problem better? _____ Does your condition affect your sleep? ☐ Yes ☐ No

Have you been treated before? ☐ Yes ☐ No If yes, when? _____ By Whom? _____

Height: _____ Weight: _____ Have you experienced any sudden weight loss or gain? ☐ Yes ☐ No

Have you EVER used tobacco (smoke/chew)? ☐ Yes ☐ No Do you use tobacco (smoke/chew) currently? ☐ Yes ☐ No

If yes, how many cigarettes per day? _____ For how many years? _____ If no when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____ ☐ Only socially

Do you or have you ever used recreational drugs? ☐ Yes ☐ No Which ones? _____

Please list all prescribed medication, over the counter medications, vitamins, herbals and supplements taken in the last 6 months. **Important:** By signing this form you attest that the list is current and not missing a current prescription.

DATE	MEDICATION	DOSE	FREQUENCY TAKEN	DISCONTINUED

MEDICAL HISTORY FORM Page 2

MEDICAL HISTORY OF

☐ Thyroid Disease	☐ High Blood Pressure	☐ Tuberculosis	☐ Malignant Hyperthermia
☐ Blood/Bleeding Disorder	☐ Stroke/CVA/TIA	☐ Ear Infections	☐ Chicken Pox/Shingles/Fever Blisters
☐ Migraines	☐ High Cholesterol	☐ Sinus Infections	☐ Reflux/GERD/Hiatal Hernia
☐ Asthma	☐ Heart Disease	☐ HIV	☐ Irritable Bowel/Crohn's Disease
☐ Lung Disease	☐ Kidney Disease	☐ Mental Illness	☐ Hepatitis/Liver Disease
☐ Emphysema/COPD	☐ Diabetes	☐ Depression	☐ Are you pregnant? ☐ Yes ☐ No
☐ Rheumatic Heart Disease	☐ Cancer Type:	☐ Arthritis	☐ Other:
☐ Skin Disease/Psoriasis	☐ Sleep Apnea	☐ Osteoporosis	

ALLERGIES / INTOLERANCES

☐ No Known Drug Allergies (NKDA)

Medication	Reaction	Medication	Reaction

SURGICAL / HOSPITALIZATION HISTORY

☐ See Attached List

Type of Surgery		Surgery Date	Type of Surgery		Surgery Date
Hospitalized for	Name of Hospital	Date	Hospitalized for	Name of Hospital	Date

FAMILY HISTORY Has any member of your family (including parents, and siblings) ever had any of the following:

Illness	Alive/ Deceased	Family Member(S)	Illness	Alive/ Deceased	Family Member(S)
☐ Cancer; Type:	☐ / ☐		☐ Glaucoma	☐ / ☐	
☐ Hypertension (High Blood Pressure)	☐ / ☐		☐ Bleeding Disorder	☐ / ☐	
☐ Diabetes	☐ / ☐		☐ Hearing Loss	☐ / ☐	
☐ Heart Disease	☐ / ☐		☐ Allergies	☐ / ☐	
☐ Sinusitis	☐ / ☐		☐ Asthma	☐ / ☐	
☐ Mental Illness	☐ / ☐		☐ Thyroid Disease	☐ / ☐	
☐ Migraine	☐ / ☐		☐ CVA (Cerebral infarction)	☐ / ☐	
☐ Drug or Alcohol Abuse	☐ / ☐		☐ Dizziness	☐ / ☐	
☐ Stroke	☐ / ☐		☐ Other	☐ / ☐	

MEDICAL HISTORY FORM Page 3

REVIEW OF SYSTEMS Please indicate if you are currently having problems with any of the following:

☐ Fever	☐ Visual Disturbance	☐ Hearing Loss	☐ Difficulty Swallowing	☐	Shortness of Breath
☐ Recent Weight Gain	☐ Dry Eyes	☐ Chest Pain	☐ Easy Bruising	☐	Cough
☐ Recent Weight Loss	☐ Double Vision	☐ Irregular Heart Rhythm	☐ Bleeding Disorder	☐	Headache
☐ Night Sweats/Chills	☐ Nosebleed	☐ Murmur	☐ Anemia	☐	Stroke
☐ Fatigue	☐ Change in Voice	☐ Leg Swelling	☐ Blood Transfusions	☐	Paralysis
☐ Skin Cancer	☐ Ringing in Ears	☐ Sleep Problems	☐ Arthritis	☐	Weakness
☐ Healing Problems	☐ Allergies	☐ Temperature Intolerance	☐ Pain in Jaw with Chewing	☐	Tingling Numbness
☐ Rash	☐ Snoring	☐ Excessive Thirst	☐ Muscle Weakness	☐	Seizures
☐ Skin Discoloration	☐ Ear Pain or Itch	☐ Loss of Appetite	☐ Leg Cramps	☐	Dizziness
☐ Hives	☐ Throat Pain	☐ Nausea or Vomiting	☐ Neck Pain	☐	Memory Loss
☐ Allergic Reactions	☐ Sinus Problems	☐ Heartburn	☐ Muscle Aches	☐ Y N	Have you had any falls in the last year?
☐ Glaucoma	☐ Ear Drainage	☐ Change in Bowel	☐ Asthma	☐ Y N	Have you had any falls with injury in the

REVIEW OF SYMPTOMS, SINUS AND ALLERGY Please grade each of the following:

	NONE	MILD	MODERATE	SEVERE
Dark Circles Under Eyes	☐	☐	☐	☐
Itchy / Watery Eyes	☐	☐	☐	☐
Red Eyes	☐	☐	☐	☐
Swollen / Puffy Eyelids	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐
Ear Pain/Pressure	☐	☐	☐	☐
Ear Popping	☐	☐	☐	☐
Congestion / Blocked Nose	☐	☐	☐	☐
Decreased Sense of Smell	☐	☐	☐	☐
Nasal / Sinus Drainage	☐	☐	☐	☐
Nose Bleeds	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐
Sinus Infection	☐	☐	☐	☐
Sinus Pressure / Pain	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐
Snoring	☐	☐	☐	☐
Snorting	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐
Hoarseness	☐	☐	☐	☐
Post-Nasal / Throat Drainage	☐	☐	☐	☐
Throat Clearing	☐	☐	☐	☐

MEDICAL HISTORY FORM Page 4

REVIEW OF SYMPTOMS, EAR *Please fill out if you have hearing issues:*

What are your hearing issues? ☐ Hearing Loss ☐ Earache ☐ Ringing ☐ Infection ☐ Clogged Ears

Other (please describe) _____ When did it begin? _____

Are you experiencing: ☐ Ear Drainage ☐ Dizziness ☐ Balance Issues ☐ Headaches ☐ Vision Issues ☐ Speech Issues

Which ear bothers you the most? ☐ Right ☐ Left ☐ Both

How would you describe the sounds? ☐ Buzzing ☐ Humming ☐ Bells ☐ Heartbeat ☐ Ringing ☐ Other _____

What time of the day does the noise bother you the most? ☐ Day ☐ Evening ☐ Night

Do you experience dizziness, if so, how often? _____ Last time when? _____

Do you experience the following conditions with the dizziness:

☐ Nausea ☐ Vomiting ☐ Head Pressure ☐ Loss of Balance ☐ Blacking Out ☐ Numbness/Weakness ☐ Speech Problems

Do you experience hearing loss? ☐ Yes ☐ No If yes, have you had a hearing test recently ☐ Yes ☐ No

REVIEW OF SYMPTOMS, SLEEP *Please fill out if you have sleeping issues:*

	NONE	MILD	MODERATE	SEVERE
Frequent Heavy Snoring	☐	☐	☐	☐
Affecting the Sleep Of Others	☐	☐	☐	☐
Significant Daytime Drowsiness	☐	☐	☐	☐
Difficulty Falling Asleep	☐	☐	☐	☐
Others Told Me "I Stop Breathing" When Sleeping	☐	☐	☐	☐
Gasping When Waking Up	☐	☐	☐	☐
Nighttime Choking Spells	☐	☐	☐	☐
Feeling Unrefreshed in The Morning	☐	☐	☐	☐
Morning Hoarseness	☐	☐	☐	☐
Morning Headaches	☐	☐	☐	☐
Swelling in Ankles or Feet	☐	☐	☐	☐
Nocturnal Teeth Grinding	☐	☐	☐	☐
Jaw Pain, Facial Pain	☐	☐	☐	☐

Other issues _____

The medical information provided above is accurate to the best of my knowledge.

Signature of Patient _____

Date _____/_____/_____



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Sino-Nasal Outcome Test (SNOT-22) Questionnaire

Name: _____

DOB: _____

Date: _____

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. 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. Please rate your problems as they have been over the past two weeks. Thank you for your participation.

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)

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MEDICAL INFORMATION PRIVACY Page 1

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to: (a) Get a copy of your paper or electronic medical record; (b) Correct your paper or electronic medical record; (c) Request confidential communication; (d) Ask us to limit the information we share; (e) Get a list of those with whom we've shared your information; (f) Get a copy of this privacy notice; (g) Choose someone to act for you; (h) File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we: (a) Tell family and friends about your condition; (b) Provide disaster relief; (c) Include you in a hospital directory; (d) Market our services and sell your information; (e) Raise funds.

Our Uses and Disclosures

We may use and share your information as we: (a) Treat you; (b) Run our organization; (c) Bill for your services; (d) Help with public health and safety issues; (e) Do research; (f) Comply with the law; (g) Respond to organ and tissue donation requests; (h) Work with a medical examiner or funeral director; (i) Address workers' compensation, law enforcement, and other government requests; (j) Respond to lawsuits and legal actions.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for five years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Patient Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Acknowledgement of Practice's Notice of Privacy Practices

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices or understand I can always request a copy. I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

Signature of Patient or Personal Representative

Date: ____/____/____

If Not Signed by Patient Print Name of Personal Rep

Description of Personal Representative's Authority

Above signature was not obtained because of the following:

- ☐ Patient is unable to sign and is unaccompanied by a representative. Patient left with all pertinent disclosures.
- ☐ Patient refused to sign
- ☐ Patient refused the forms

Designation of Certain Relatives, Close Friend or Caregivers as my Personal Representative

I agree that the practice may disclose certain sections of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name	Relationship to you	Telephone	What we may disclose
			☐ Any and All Information ☐ Other _____
			☐ Any and All Information ☐ Other _____
			☐ Any and All Information ☐ Other _____

Request to Receive Confidential Communications by Alternative Means:

As Provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below:

Home Phone		☐ OK to leave message with detailed information ☐ Leave message with call back numbers only
Cell Phone		☐ OK to leave message with detailed information ☐ Leave message with call back number only

Signature of Patient

Date