Penn Medicine
Hospital *of the* University *of* Pennsylvania

Department of Otorhinolaryngology
Smell and Taste Center

Richard L. Doty, Ph.D.
Professor and Director

Appointment Reminder

You have been scheduled for an appointment at the Smell and Taste Center for an evaluation and treatment recommendation.

Appointment Date: _____, _____, , 2019, at 8:00 AM. Please keep in mind that this is an 8 hour appointment!

Please mail packet back by - - 2019, via FedEx or UPS.
Please do NOT send packet back via USPS or FAX.

The Smell and Taste Center
The Hospital of the University of Pennsylvania
3400 Spruce Street, 5 Ravdin Building
Philadelphia, PA 19104
Attention: Crystal Wylie

1. We ask that you only get a prescription from a doctor that recommended you visit us if you can; if you cannot, that is ok--it is not required. If your insurance requires a referral please make sure you obtain one through your primary care or referring physician.
2. If YOU feel that YOU would like to see an ENT here at UPenn please make sure your doctor's office can have a referral ready if needed. For ENT appointments please call 215-662-2778; this is not required, but normally the ENT office is booked several months in advance. We have no way to know if you will or will not need to see someone; if YOU think YOU do, then please make an appointment.
3. We do not need films; please only send copies of WRITTEN reports.
4. Make sure you fill out and return the entire packet at least 2 weeks prior to your appointment. We suggest you do not send by regular mail, but if you do please make a copy and bring the copies with you. DO NOT FAX or EMAIL packet. **We prefer you send back the documents via UPS or FedEx.**
5. Please bring a lunch!!! In order for the testing process to proceed smoothly, you will not be able to leave the waiting area to get something to eat. Please note, there is **no refrigeration available** for your food.
6. If you bring family or friends with you, please note that only you and the tester will be permitted in testing areas. It is not a large waiting area and guests of patients may be required to go to another waiting area.
7. All payments must be made via credit card unless advance arrangements have been made to pay by check. Sorry but we do not accept cash at our office.

If you should have any questions about this packet, please feel free to call **Crystal Wylie** at 215-662-2797 or email Crystal.Wylie@uphs.upenn.edu, Monday thru Friday, 9 am to 1 pm.

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

PATIENT REGISTRATION QUESTIONNAIRE

Update ☐ *New* ☐

In order to keep your records up to date, please answer the following questions on both sides of the form.

LOCATION	PATIENT IDENTIFICATION NUMBER/MRN	TEMPORARY ACCT. NUMBER	VERIFIED BY/DATE

NAME OF PATIENT

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

DATE OF BIRTH SEX: M F

EMERGENCY CONTACT

( )

AREA CODE EMERGENCY CONTACT TELEPHONE

FATHER'S NAME: _____ MOTHER'S NAME: _____

MAIDEN NAME: _____

RACE: * Arab: _____ Asian: _____ Black: _____
Caucasian: _____ Hispanic: _____ Indian: _____
Other: _____

MARITAL STATUS:* Married _____ Single _____ Divorced _____
Widowed _____ Separated _____ Other _____

*It is not mandatory to answer this question. However for statistical purposes, your answers would be appreciated.

GUARANTOR INFO (IF DIFFERENT THAN PATIENT)

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

DATE OF BIRTH SEX: M F

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

RELATIONSHIP TO GUARANTOR

( )

AREA CODE

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

PATIENT ADDRESS

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE HOME TELEPHONE

( )

AREA CODE DAY TELEPHONE

EMAIL ADDRESS

PATIENT EMPLOYMENT INFORMATION

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

OCCUPATION

PRIMARY CARE/FAMILY PHYSICIAN

MD DO

NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

COMMENTS:

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
PATIENT REGISTRATION QUESTIONNAIRE

PATIENT NAME

PATIENT IDENTIFICATION NUMBER/MRN

PRIMARY INSURANCE (please "✓" the appropriate box below)

☐ BC/BS ☐ Commercial ☐ HMO/PPO ☐ POS

NAME OF INSURANCE CO.

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

CERTIFICATE NUMBER

GROUP NUMBER

PLAN NUMBER MEDICARE PLAN? Y or N

EFFECTIVE DATE EXPIRATION DATE

( ) AREA CODE TELEPHONE

SUBSCRIBER NAME (IF DIFFERENT)

RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER'S BIRTHDAY

SUBSCRIBER'S SEX: M or F

SECONDARY INSURANCE (please "✓" the appropriate box below)

☐ BC/BS ☐ Commercial ☐ HMO/PPO ☐ POS

NAME OF INSURANCE CO.

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

CERTIFICATE NUMBER

GROUP NUMBER

PLAN NUMBER MEDICARE PLAN? Y or N

EFFECTIVE DATE EXPIRATION DATE

( ) AREA CODE TELEPHONE

SUBSCRIBER NAME (IF DIFFERENT)

RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER'S BIRTHDAY

SUBSCRIBER'S SEX: M or F

MEDICAL ASSISTANCE

RECIPIENT NUMBER

CARD ISSUE NUMBER

MANAGED CARE/MEDICAL ASSISTANCE PLAN NAME:

IDENTIFICATION NUMBER

MEDICARE *Please Answer Questions Below*

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A)

MEDICAL (PART B)

WORKER'S COMPENSATION/AUTO ACCIDENT INFO

(Please Circle Either Worker's Compensation or Auto Accident)

INSURANCE CARRIER'S NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE TELEPHONE

DATE OF INJURY/ACCIDENT

CLAIM NUMBER/POLICY NUMBER

MULTIPLE CLAIMS? Y or N

Medicare Questions (Please Circle Y or N)

Are you or your spouse employed?	**Y or N**
Do you or your spouse have other insurance?	**Y or N**
Are you disabled or have end stage renal disease?	**Y or N**
Is this illness or injury the result of an auto accident?	**Y or N**
Did this illness or injury occur at work?	**Y or N**
Has treatment been authorized by the V.A.?	**Y or N**
Are you covered under the Black Lung Program?	**Y or N**
Is there Medigap coverage secondary to Medicare?	**Y or N**
Is there employer supplemental insurance secondary to Medicare?	**Y or N**
Is there insurance coverage primary to Medicare?	**Y or N**

Penn Medicine

HUP PPMC PAH

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NAME SEX M F

MRN

AGE DATE OF BIRTH

ACCOUNT #

(PATIENT PLATE IMPRINT)

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

Disclosed Information: (check all items to be released) ❑ **Entire Record** ❑ **Abstract**

❑ Discharge Summary ❑ Operative Report ❑ Lab Reports ❑ Radiology Images
❑ Discharge Instructions ❑ ER Record ❑ EKG/ECG Tests ❑ Medication Records
❑ History and Physical ❑ X-Ray Reports ❑ Progress Notes ❑ Physician Orders
❑ Consultations
❑ Other (please specify) _____
Covering the period(s) of care (list applicable dates of treatment) _____

Special Records:

I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below.

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
❑ Yes, disclose	❑ Yes, disclose	❑ Yes, disclose
❑ No, do not disclose	❑ No, do not disclose	❑ No, do not disclose

Location of Services:

❑ HUP ❑ PAH ❑ PPMC ❑ Penn Home Care & Hospice Service (PHCHS)
❑ CPUP/CCA Outpatient Practice(s): _____ Other: _____

Information To Be Provided To:

Name of Person or Institution

_____

Address

_____

City/State/Zip Code	Telephone Number

Purpose/Use Of The Requested Information:

❑ Personal use by patient ❑ Sharing with other health care providers
❑ Other (please describe) _____

Format: ❑ Paper Copy ❑ Electronic Copy (provided on encrypted disk)

Authorization

I hereby authorize Penn Medicine to disclose the health information described above.

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.

My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.

_____

Signature of Patient or Personal Representative Print Name Date

_____

Relationship of Personal Representative to Patient Date

If Authorization is signed by someone other than the patient, please state reason. _____

PLEASE READ INSTRUCTIONS ON REVERSE

Penn Medicine
Hospital *of the* University *of* Pennsylvania

Smell and Taste Center
Department of Otorhinolaryngology

HIPAA

Signature of Patient or
Legally Authorized Representative

Date

Printed Name of
Legally Authorized Representative

Legal Relationship to Patient
(e.g., parent or guardian)

GENERAL CONSENT TO
USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This is a consent form. It asks you to permit us to use and disclose information about your health in keeping with both state and Federal law. This information is called "protected health information." It is any information we receive or create that identifies (or could identify) you and deals with your physical or mental health, any health care we provide you and/or payment for such health care.

By signing this form, you are consenting to our use and disclosure of your protected health information in order to carry out treatment, payment or health care operations, as further explained in our "Notice of Privacy Practices" (the "Notice").

By signing this form, you also acknowledge that you have received our Notice. This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this consent.

Before releasing any information about your treatment for drug abuse, alcohol abuse or mental illness, and HIV or AIDS, other than as permitted or required by law, we will ask you to sign a separate consent form.

You also have the right to revoke this consent, in writing, except where we have previously taken action in reliance on your prior consent.

If you refuse to sign this consent form, we will not be able to treat you.

5 Ravdin | 3400 Spruce Street | Philadelphia, PA 19104-4283 | Phone: 215.662.6580 | Fax: 215.349.5266

Payment Agreement
For Various Insurance Subscribers
University of Pennsylvania Health System: The Smell and Taste Center

Welcome to the Hospital of the University of Pennsylvania. We appreciate your confidence in choosing our hospital for your health care needs.

Several local insurance carriers may not cover the total charges for outpatient diagnostic testing (procedure codes: 92512, 92700, 95900; diagnostic code: 781.1) at the Smell and Taste Center. In response to their policy, the Smell and Taste Center requires a non-refundable $450.00 payment to be made before any services are provided. If the insurance company does not pay our estimated charges, the payment will not be refunded. The $450.00 payment will be considered payment in full and charges will be adjusted to reflect $450.00 and not the full cost of testing. Therefore, you will not be charged more than $450.00 for this appointment, unless you are involved in a litigation case.

My signature indicates that I accept Payment Agreement.

All patients must sign below regardless of your health insurance coverage.

PATIENT SIGNATURE: _____

DATE: _____

Penn Medicine
Hospital *of the* University *of* Pennsylvania

Smell and Taste Center
Department of Otorhinolaryngology

Richard L. Doty, Ph.D.
Professor and Director

AOB – Assignment of Benefits

Assignment of Benefits: I am receiving medical care and services by the physicians of the Clinical Practices of the University of Pennsylvania and/or Clinical Care Associates (System Provider(s)). In exchange for that care and treatment, I give and assign to one or more of the System Providers, as appropriate, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called "assignment of benefits: and that the System Providers may be called my "assignees." This assignment shall not be for more than the physicians charges. I understand that I may be required to pay for charges that others do not pay on my behalf under this assignment. I agree that the System Providers can sue anyone in their own names as my assignee and get payment for the charges resulting from my medical care. This amount may include charges on the bill for my care and lawyer's fees resulting from collection efforts.

Medicare Benefits: I request that payment of Medicare benefits be made on my behalf to one or more of the System Providers for any medical services, care or treatment any of them may provide to me. I authorize the System Providers and their agents to give the Centers for Medicare and Medicaid Services and its agents any medical information about me (or the person I signed for) needed to determine these benefits payable for related services. I have provided accurate information about Medicare secondary payers.

_____ _____

Patient Date

_____ _____

Patient's spouse, parent, child or other responsible Party individually and as agent for patient

Relationship to Patient

5 Ravdin I 3400 Spruce Street I Philadelphia, PA 19104-4283 I Phone: 215.662.6580 I Fax: 215.349.5266

Insurance Company Information

Below is a list of procedures that will be preformed on the day of clinic,
and that you may need when speaking with your insurance company to verify coverage and payments.

	(Diagnosis Code: 781.1) (Referring Doctor Natasha Mirza, NPI# 1508895020) (Tax ID# 232706750)	
PROCEDURE CODE	**DESCRIPTION**	**COST**
92700D	**Intake/Exit Interview and History Questionnaire:** The review of Olfactory and Taste History and 350 item intake Questionnaire	**$ 309.00**
92700F	**Bilateral Smell Threshold Test:** Bilateral testing of smell acuity using phenyl ethyl alcohol.	**$ 309.00**
92700E	**Smell ID Test (UPSIT):** The University of Pennsylvania Smell Identification test. This bilateral test is a microencapsulated olfactory test that is routinely administered by many physicians throughout the world.	**$ 180.00**
92700H	**Smell Threshold Unilateral Testing:** A detection threshold measurement of the smell acuity within each naris using the odorant phenyl ethyl alcohol.	**$ 290.00**
92700I	**Taste-Suprathreshold Test:** A test of the patient's whole mouth taste ability that uses various concentrations of sweet, sour, bitter and salty stimuli to establish suprathreshold determinates of taste dysfunction.	**$ 335.00**
92700J	**Taste Quadrant Test:** A test to ascertain whether localized deficits are present on regions of the tongue subserved by the left and right chords tympani and the left and right glossopharyngeal nerves.	**$ 412.00**
92512A	**Acoustic Rhinometry:** A sonar-like procedure for determining the volume of the nasal chamber.	**$ 258.00**
92700K	**Nasal Air Flow:** An anterior rhinomanometric procedure for determining the resistance of the airflow within each side of the nose.	**$ 290.00**
95900A	**Electrogustometry:** A threshold measurement of the lowest electric current (in microamperes) detectable on each side of the tongue. This test provides a means of assessing basal nerve sensitivity.	**$ 290.00**
92700L	**Smell Suprathreshold Odor Memory Test:** A test designed to assess central components of smell dysfunction.	**$ 258.00**
		$ 2,931.00

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

22 23 24 25 26 27 28 29 30 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

BAI®

NAME _____ **DATE** _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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40 41 42 43 44 45 A B C D E
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SMELL AND TASTE CENTER

University of Pennsylvania Medical Center

Handedness inventory

3400 Spruce Street, Philadelphia, PA 19104-4283

Today's Date: _____

Name: _____ Age: ___ Sex: ____Male ____Female

Ethnicity: _____American Indian _____Asian/Pacific _____Black _____Hispanic _____White _____Other

Indicate hand preference	Always Left	Usually Left	No preference	Usually Right	Always Right
1. To write a letter legibly					
2. To throw a ball to hit a target					
3. To play a game requiring the use of a racquet					
4. At the top of a broom to sweep dust from the floor					
5. At the top of a shovel to move sand					
6. To hold a match when striking it					
7. To hold scissors to cut paper					
8. To hold tread to guide through the eye of a needle					
9. To deal playing cards					
10. To hammer a nail into wood					
11. To hold a toothbrush while cleaning teeth					
12. To unscrew the lid of a Jar					

Are/were either of your (natural) parents left-handed? _____ Yes _____ No If yes which? _____

How Many siblings of each sex do/did you have? Male _____ Female ____

Which eye do you use when using only one (e.g. telescope, keyhole)? _____Left _____Right

Have you ever suffered any severe head trauma? _____Yes _____ No

Staff Use: _____

(Adapted from: Briggs, G.G. and Nevers, R.D. 1975 Cortex, 11:232