

The Ear, Nose, Throat & Plastic Surgery Associates

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Date: _____

PLEASE PRINT LEGIBLY

Chart # _____

PATIENT INFORMATION

Legal Name: Mr. Mrs. Ms. _____
(Circle One) (Last) (First) (Middle)

Address: _____
(Street) (Apt. #) (City) (State) (Zip + 4)

Mailing Address: _____
(if different from above) (Street) (Apt. #) (City) (State) (Zip + 4)

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

E-Mail Address: _____

Patient's Occupation: _____ Patient's Employer or School: _____

Child Single Divorced Married Widow Date of Birth: _____ Age: _____ M F

Patient's Social Security #: _____ Spouse Parent Guardian (Name): _____
(Circle One) (If Guardian, please provide copy of court order)

Primary Care Physician (PCP): _____ Address: _____ Phone: _____

Referring Physician: _____ Address: _____ Phone: _____

Preferred Language (Mark Only One) English Spanish

Race: (Mark Only One) White American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander Some Other Race Decline to State

Ethnicity (Mark Only One) Hispanic or Latino Not Hispanic or Latino Decline to State

COMPLETE SECTION BELOW IF YOU ARE A PARENT/GUARDIAN OF A MINOR PATIENT

Legal Name: Mr. Mrs. Ms. _____ M F D.O.B. _____ SS#: _____
(Circle One) (Last) (First) (Middle)

Mailing Address: _____
(Street) (Apt. #) (City) (State) (Zip + 4)

Home Phone: (_____) _____ Work Phone: (_____) _____ Relationship to Patient: _____

Employer of Responsible Party: _____ Name of Spouse: _____

INSURANCE COMPANY INFORMATION (Complete and give us your card to copy.)

Name of Primary Insurance: _____

Primary Insured's Name: _____ D.O.B. _____ Social Security #: _____

If insurance card is not available, please fill in the following information on your primary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone: _____ Group Name or No. _____ I.D. No. _____

Name of Secondary Insurance: _____

Primary Insured's Name: _____ D.O.B. _____ Social Security #: _____

If insurance card is not available, please fill in the following information on your secondary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone: _____ Group Name or No. _____ I.D. No. _____

Signatures Required on Back of Form

Signature Required in Two Places

FINANCIAL POLICY PLEASE READ

Payment of charges is due at the time service is rendered, with the exception of HMO and PPO contracts. The patient will be given itemized receipts that will be sufficient to submit to an insurance company for reimbursement. In the event of a hospital admission and/or surgery, the office will file the charges to your insurance company, as a courtesy. However, financial responsibility remains with the patient. Any amount not covered by the insurance company is due from the patient. Accounts that have balances that are over 90 days past due could possibly be turned over to a collection agency unless previous arrangements have been made.

HMO & PPO CONTRACTS

The office will file charges for the plans we participate with. Co-payments are due at the time services are rendered.

MEDICARE

The Ear, Nose, Throat and Plastic Surgery Associates accepts assignment on all Medicare claims. Please provide us with any additional insurance coverage you may have.

PATIENT RESPONSIBILITY

All patients are responsible for knowing the requirements of their insurance plans, including which labs and radiology facilities they may use, what services are covered, etc. Our staff will assist our patients, but we cannot be responsible for knowing or interpreting the benefits of each individual policy.

PLEASE READ AND FILL OUT COMPLETELY

Please list any family members or significant others that you give your authorization for this practice to discuss any non-emergency medical/billing issues if you are not readily available. For example, if someone were to call on your behalf, they need to be listed here. *If none, write "None"*.

Name, Relationship To You and Phone Number: _____

You are responsible for notifying this practice of any changes to this list.

PLEASE READ AND SIGN THIS PATIENT CONSENT:

I hereby give my consent for any and all examinations, treatment, therapy, care, anesthetics, ear cleaning, administration of medications, and diagnostic procedures including scopes, during the course of my care. The risks and complications may include but are not limited to bleeding, infection, damage to adjacent tissues or organs, swelling, pain, anesthesia, or medication reactions.

Signature: _____ **Date:** _____

YOUR SIGNATURE WILL SERVE FOR ANY OR ALL OF THE FOLLOWING:

I hereby give consent to The Ear, Nose, Throat and Plastic Surgery Associates to provide the necessary treatment the assigned physician and I have discussed.

I am aware that payment is expected at the time service is rendered.

Notice of Privacy Practices: I have received the Notice of Privacy Practices.

Authorization of Medical Release: I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefits either to myself or to the party who accepts assignment.

Lifetime Signature Authorization for Medicare: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.

Insurance Authorization (applies only as stated above): I authorize payment of medical benefits to the attending physician for services described.

I permit a copy of these authorizations and assignments to be used in place of this original that is on file at the physician's office.

Signature: _____ **Date:** _____

Responsible Party

I have reviewed both sides of this medical history form. Physician Signature: _____

(Nurse to Complete: Blood Pressure: _____ Temp: _____ Pulse: _____ BMI: _____ Year Reported _____)

BMI: _____ Year Reported _____

New or Updated Patient Medical History (17 years or older)

In order for you to receive high quality care, **please answer all questions.** (Update Required Every Year.)

Name: _____ Date of Birth: _____ Your Primary M.D. _____

Date Form Filled Out: _____ Date of Appt: _____ Your Age: _____ Your Height: _____ Your Weight: _____

Which Physician Outside Of Our Group Sent You to Our Office For This Consultation (Office Visit)?: _____
(Physician First and Last Name)

Briefly, why are you seeing our physician today? _____

HAVE YOU RECENTLY SEEN ANOTHER PHYSICIAN FOR THIS CURRENT ILLNESS? YES NO

REVIEW OF SYSTEMS

INDICATE BELOW ANY SYMPTOMS **YOU ARE CURRENTLY HAVING:**
Please mark the NO column if you do not have these symptoms.

1. CONSTITUTIONAL: A. Fatigue B. Weight Loss C. Fevers D. Chills E. Nausea F. Headaches	YES	NO	7. ALLERGIC: A. (circle) Itchy eyes, ears, nose, palate B. Watery Eyes C. Scratchy Throat D. Sneezing Excessively	YES	NO
2. SKIN: A. Lesions			8. MOUTH: A. Lesions B. Loss of Taste		
3. EYES: A. Double Vision B. Blurred Vision C. Loss of Vision			9. THROAT: A. Pain B. Hoarseness C. Cough D. Difficulty Swallowing E. Indigestion, Heartburn		
4. EARS: A. Hearing Loss B. Family History C. Exposure-Loud Noises D. Drainage E. Pain F. Noise in Ears (Tinnitus) G. Dizziness H. Hearing Aids			10. NECK: A. Pain and/or Lumps		
5. NOSE: A. Pain B. Discharge C. Post Nasal Drip D. Deformity E. Congestion F. Decreased Smell G. Bleeding H. Snoring			11. HEART AND CIRCULATION: A. Chest Pain B. Irregular Heart Beat C. Leg Swelling		
6. ENDOCRINE: A. Heat or Cold Intolerance B. Unusual Hair Loss (Alopecia)			12. LUNGS: A. Shortness of Breath B. Congestion C. Wheezing D. Productive Cough		
			13. NERVES: A. Numbness B. Localized Weakness C. Paralysis		
			14. STOMACH AND INTESTINES: A. Nausea and/or Vomiting		
			15. BLOOD SYSTEM: A. Bleeding or Easy Bruising		

CONTINUED ON BACK PAGE

Please Print Your Name on Top of Back Page

Patient Name: _____

PAST HISTORY

	Yes	No		Yes	No
History of Exposure to HIV	_____	_____	Problems with General Anesthesia	_____	_____
Positive test for HIV (AIDS Virus)	_____	_____	History of Allergy Evaluation	_____	_____
Previous Surgery	_____	_____	History of Allergy Treatment	_____	_____

If you have had surgery, list the surgery with approximate dates:

INDICATE BELOW ANY HISTORY OF DISEASES YOU HAVE HAD

Medical Illnesses:	Yes	No		Yes	No
Lung Disease	_____	_____	Hypertension (High Blood Pressure)	_____	_____
Asthma	_____	_____	Urinary Disease	_____	_____
Heart Disease	_____	_____	Pelvic Disease	_____	_____
Blood Vessel Disease	_____	_____	Prostate Disease	_____	_____
Glaucoma	_____	_____	Kidney Disease	_____	_____
Arthritis	_____	_____	Diabetes	_____	_____
Bleeding tendency	_____	_____	Hepatitis	_____	_____
Seizures	_____	_____			

List any other health conditions _____

ALLERGIES TO MEDICATION

FAMILY HISTORY

INDICATE BELOW THE DISEASE IN YOUR PARENTS, BROTHERS OR SISTERS

	Yes	No		Yes	No
Cancer	_____	_____	Hearing Loss	_____	_____
Heart Disease	_____	_____	Bleeding Abnormalities	_____	_____
Hypertension (High Blood Pressure)	_____	_____	Anesthesia Complications	_____	_____
Lung Disease	_____	_____	Allergies	_____	_____

List any other health conditions _____

SOCIAL HISTORY

Current or Previous Occupation: _____

	Yes	No	
Are you retired?	_____	_____	
Are you pregnant?	_____	_____	
Caffeine Use?	_____	_____	
Alcohol Use?	_____	_____	Amount _____ per week.
Recreational Drug Use:	_____	_____	
Tobacco Use?	_____	_____	

Year Quit _____ If smoking, type of tobacco _____ # _____ of packs per day for # _____ years.

The above information is correct.

Patient Signature: _____

PATIENT MEDICATION HISTORY

Full Name: _____ Date of Birth: _____ Age: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

CURRENT MEDICATIONS

Are you taking ANY kind of medication now? This includes prescription, over-the-counter or herbal medications. ___ Yes ___ No

Medication Name	Dosage	How Often Taken

Medication Allergies: Are you allergic to any medications? ___ Yes ___ No

If yes, please list below:

Name of Medication	Type of Reaction (Rash, Swelling, Etc.)