The Ear, Nose, Throat & Plastic Surgery Associates

Drs. Ho • Lehman • Kielmovitch • Baylor • Tipirneni • Spector • Patni • Tran • Kang • Jadidian • Woodson • Johnson

PA-C: Jeff Fichera • Jessica Curley • Farida Hussain • Rebecca Korman • Jeffery Wilson

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

Revised 9/27/17

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.

	YES	NO
1. CONSTITUTIONAL:		
A. Fatigue	____	____
B. Weight Loss	____	____
C. Fevers	____	____
D. Chills	____	____
E. Nausea	____	____
F. Headaches	____	____
2. SKIN:		
A. Lesions	____	____
3. EYES:		
A. Double Vision	____	____
B. Blurred Vision	____	____
C. Loss of Vision	____	____
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	____	____
5. NOSE:		
A. Pain	____	____
B. Discharge	____	____
C. Post Nasal Drip	____	____
D. Deformity	____	____
E. Congestion	____	____
F. Decreased Smell	____	____
G. Bleeding	____	____
H. Snoring	____	____
6. ENDOCRINE:	____	____
A. Heat or Cold Intolerance	____	____
B. Unusual Hair Loss (Alopecia)	____	____

	YES	NO
7. ALLERGIC:		
A. (circle) Itchy eyes, ears, nose, palate	____	____
B. Watery Eyes	____	____
C. Scratchy Throat	____	____
D. Sneezing Excessively	____	____
8. MOUTH:		
A. Lesions	____	____
B. Loss of Taste	____	____
9. THROAT:		
A. Pain	____	____
B. Hoarseness	____	____
C. Cough	____	____
D. Difficulty Swallowing	____	____
E. Indigestion, Heartburn	____	____
10. NECK:		
A. Pain and/or Lumps	____	____
11. HEART AND CIRCULATION:		
A. Chest Pain	____	____
B. Irregular Heart Beat	____	____
C. Leg Swelling	____	____
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 HEALTH/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.)

Previous Cancer Screening/Tests

Mammogram: __Yes __ No Most Recent Year Performed: _____
Pap Smear: __ Yes __ No Most Recent Year Performed: _____
Colonoscopy: __ Yes __ No Most Recent Year Performed: _____
HPV Testing: __ Yes __ No Most Recent Year Performed: _____

Previous Flu Shot: __ Yes __ No Most Recent Year Received:_____
If no, please provide a reason (i.e. allergy to injection, declined, etc.)_____