The Ear, Nose, Throat & Plastic Surgery Associates

Drs. Ho • Lehman • Kielmovitch • Baylor • Tipirneni • Spector • Patni • Tran • Kang • Jadidian • 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 1/8/19

PATIENT HEALTH/MEDICATION HISTORY

Full Name: ________________________________ Date of Birth: ________________ Age: _______

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your physician to know that you have carefully reviewed every area of this form.

What is the main reason you are here to see the physician today?

____

How long have you been experiencing this problem?
___ Hours ___ Days ___ Months ___ Years

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.)

Have you had any surgery or procedures? __ Yes __ No If yes, please list below.

Problems with anesthesia? ___ Yes ___ No

Type of Surgery or Procedure	Date of Surgery or Procedure

Have You Had:
Flu Shot: __ Yes __ No Most Recent **Month** and Year Received:______________
If no, please provide a reason (i.e. allergy to injection, declined, etc.)______________
____
Pneumococcal Vaccine: __Yes __ No Most Recent Year Performed: ______
Mammogram: __ Yes __ No Most Recent Year Performed: ______

Current Use of Tobacco Products: __ Yes __ No