Acct#_____

PATIENT INFORMATION
EAR NOSE & THROAT ASSOCIATES, P.C.

Please complete this form. It is a confidential part of your medical record. If you have any questions about this form, please ask our front desk personnel. You must fill out **COMPLETELY** prior to being seen.

DEMOGRAPHICS

Patient Name:_____ **Date**_____

Sex: ☐ **M** ☐ **F** **Date of Birth:**_____ **Age:**_____

Home Address:_____ **Home phone#**_____

City, State, Zip: _____ **Work phone#** _____

Email: _____ **Cell phone#** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** **Spouse Name:**_____

EMERGENCY CONTACT INFORMATION with Alternate Phone number:
(Please list someone who lives outside the home of the patient.)

Person to contact in case of emergency:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No If yes, please complete the following information:

Primary Insurance Coverage:_____ Ins Phone#_____

ID# or Plan#_____ Group #:_____

Policy Holder:_____ Relationship to Policy Holder:_____

Policy Holder SS#_____ Policy Holder DOB:_____

Insured's Employer:_____ Employer Phone#:_____

Secondary Insurance Coverage:_____ Ins Phone # _____

ID# or Plan#_____ Group #:_____

Policy Holder:_____ Relationship to Policy Holder:_____

Policy Holder SS#_____ Policy Holder DOB:_____

Insured's Employer:_____ Employer Phone#:_____

If patient is a MINOR, Responsible Party Name:_____ Relationship:_____

Address:_____

Responsible Party Home Phone#:_____ Work/Cell Phone #_____

Patient Name:_____ **Acct#**_____
Date_____

CHILD MEDICAL HISTORY: (CHECK ONLY THE ISSUES THAT APPLY TO YOUR CHILD)

GENERAL:
Unexplained Fever (+2wks) ☐ YES ☐ NO
Night Sweats ☐ YES ☐ NO
Unexplained Weight Loss ☐ YES ☐ NO
Immune Deficiency ☐ YES ☐ NO

SKIN:
Rash ☐ YES ☐ NO
Acne ☐ YES ☐ NO
Psoriasis ☐ YES ☐ NO
Eczema ☐ YES ☐ NO

EYES:
Blindness ☐ YES ☐ NO
Loss of Vision ☐ YES ☐ NO
Wear Glasses/Contacts ☐ YES ☐ NO

EARS:
Loss of Hearing ☐ YES ☐ NO
Ringing ☐ YES ☐ NO
Ear Fullness/Pressure ☐ YES ☐ NO
Drainage ☐ YES ☐ NO
Pain ☐ YES ☐ NO

HEART/CIRCULATION:
Heart Murmur ☐ YES ☐ NO
Heart Defects ☐ YES ☐ NO

RESPIRATORY:
Reactive Airway Disease ☐ YES ☐ NO
Asthma ☐ YES ☐ NO
RSV ☐ YES ☐ NO
Pneumonia ☐ YES ☐ NO
Snoring ☐ YES ☐ NO
Sleep Apnea ☐ YES ☐ NO

GASTROINTESTINAL:
Esophageal Reflux ☐ YES ☐ NO
Chronic Diarrhea ☐ YES ☐ NO
Chronic Constipation ☐ YES ☐ NO
Eating Disorder ☐ YES ☐ NO

GENITOURINARY:
Undescended testes ☐ YES ☐ NO
Hypospadias ☐ YES ☐ NO
Kidney Problems ☐ YES ☐ NO
Bladder Problems ☐ YES ☐ NO

CANCER: If yes, please list_____

PETS IN HOME: ☐ YES ☐ NO
If yes, please list_____

FIREARMS IN HOME?: ☐ YES ☐ NO
IF YES, SECURED OR UNSECURED (PLEASE CIRCLE)

NEUROLOGICAL:
Seizures ☐ YES ☐ NO
Epilepsy ☐ YES ☐ NO
Head Injuries ☐ YES ☐ NO
Headaches ☐ YES ☐ NO
Dizziness ☐ YES ☐ NO

ENDOCRINE:
Thyroid Problems ☐ YES ☐ NO
Pituitary Disorder ☐ YES ☐ NO
Adrenal Problems ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO

HEMATOLOGICAL/LYMPHATIC:
Anemia ☐ YES ☐ NO
Bleeding Disorder ☐ YES ☐ NO
Lymphoma ☐ YES ☐ NO
Leukemia ☐ YES ☐ NO
Enlarged Lymph Nodes ☐ YES ☐ NO
HIV Positive ☐ YES ☐ NO

ALLERGIC:
Hay Fever ☐ YES ☐ NO
Seasonal Allergies ☐ YES ☐ NO
Environmental Allergies ☐ YES ☐ NO
Type?_____
Allergy Shots? ☐ YES ☐ NO

CHILDHOOD DISEASES:
Chicken Pox ☐ YES ☐ NO
Kawasaki Disease ☐ YES ☐ NO
Measles ☐ YES ☐ NO
Mumps ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO
Scarlet Fever ☐ YES ☐ NO

IMMUNIZATIONS UP TO DATE?
☐ YES ☐ NO
If no, what's missing?_____

FAMILY HISTORY:
Hearing Loss ☐ YES ☐ NO
Ear Disease ☐ YES ☐ NO
Problems with Anesthesia ☐ YES ☐ NO
Bleeding Disorders ☐ YES ☐ NO

Does Child Attend Daycare ☐ YES ☐ NO

CAFFEINE CONSUMPTION:
☐ None ☐ Minimal ☐ Moderate ☐ Excessive

SECOND HAND SMOKE EXPOSURE:
☐ None ☐ Minimal ☐ Moderate ☐ Excessive

Parent/Guardian Signature:_____

Physician Signature_____

Patient Name:_____ **Acct#**_____
Date_____

I was referred by:_____

Pharmacy Name:_____ Phone Number:_____

1. Chief reason for today's evaluation:_____

2. Symptoms:_____

3. Describe all previous treatments for your condition: (write NONE if nothing has been tried)

_____

_____

_____

4. Severity of Symptoms from 1 to 10: _____

GENERAL INFORMATION

Please List Your Medication Allergies **Reaction** ☐ **No Known Drug Allergies**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Please List Your Current Medications and Dosage (Prescriptions, Over-The-Counter, & Herbal) ☐ **NONE**

1._____

2._____

3._____

4._____

5._____

6._____

Please List Previous Surgeries: **Date of Surgery**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Occupation:_____

Race _____ **Language:**_____

Ethnicity: (Please Circle One) Hispanic/Latino or Non Hispanic/Latino

EAR, NOSE, AND THROAT ASSOCIATES, PC Financial Policy
Effective September 1, 2014

Patient name:_____Account#_____

Ear, Nose and Throat Associates, PC, believes that in the interest of good health care practices, it is best to establish a patient account policy between our patients and ourselves in order to avoid any misunderstandings. Our Account Representatives will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality healthcare services. We wish to spend our time and energy toward that responsibility. We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility.

(PLEASE INITIAL THE FOLLOWING)

_____1.) We expect that all co-pays and patient due balances be paid in full at each visit. We accept cash, check, debit/check card, Mastercard, VISA, American Express, and Discover.

_____2.). I authorize Ear, Nose, & Throat Associates, P.C. to release to my insurance carriers any information requested concerning my examination or treatment. I hereby authorize payment directly to Ear, Nose, & Throat Associates, P.C for surgical and medical benefits payable for services performed.

_____3.) We file claims to your insurance company for your primary and secondary policies. We will look to the patient for payment in full if insurance does not cover the services provided. Please be advised that your insurance may consider a scope or hearing test as a procedure and therefore file it toward your deductible.

_____4.). We currently use an outside company to assist us in collecting balances due by our patients that are over 90 days old. It is important that you keep up with your statements and account balances and discuss any problems you may have satisfying your account with our Account Representative

_____5.) A service charge of $35 will be applied to all returned checks. If you present two (2) checks that are returned to us, we will require cash for future services.

_____6.) Our physicians would like to take the opportunity to discuss with you any test results which we have ordered in person. In some cases, you may choose to obtain your results by phone from a medical assistant, if so there may be a $25 charge.

_____7.) We do not file insurance with your Automobile Insurance Company or Workman's Compensation plan. You will be responsible to pay for services rendered in full at time of service.

_____8.) I agree to inform Ear, Nose, and Throat Associates, PC of any changes to my address, phone numbers, or insurance information as soon as they occur.

_____9.)We expect at least 24 hour notice for all cancellations/rescheduling of appointments. *You will be charged $50 should you fail to cancel or not show for your appointment* If there are more than 3 occurrences of no show or last minute cancellations, you may be dismissed from the practice at our discretion. .

_____10.) I have been given the opportunity to review/obtain a copy of Ear, Nose, & Throat Associates, P.C.'s Notice of Privacy Practices.

Patient/Guardian
Signature_____Date_____

Acct#_____

Ear Nose & Throat Associates, P.C.
Patient Privacy Act Notice

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (Federal Law.) In compliance with HIPAA, Ear Nose and Throat Associates, P.C. requires the following information to be filled out for every patient.

It is our policy not to release confidential/unauthorized information by telephone and/or voicemail. However, we will confirm appointments by telephone. Information will not be left with unauthorized persons who may answer the phone. If you would like to have information released to someone other than yourself, please complete the following:

I, _____ (_____) hereby authorize
Relationship to Patient
Ear Nose & Throat, P.C. and staff to leave medical information by the following methods and will assume responsibility to notify Ear Nose & Throat Associates, P.C. when this information changes.

Home Telephone _____ Yes No Cell Phone_____ Yes No

Work Telephone_____ Yes No

I, _____ (_____) hereby authorize
Relationship to Patient
Ear Nose & Throat, P.C. and staff to speak with and discuss the above named patient's medical care with the persons named below. This also includes people who have permission to bring a minor child to our office and assume medical decision making in the parent/guardian's absence.

Name and Relationship	Contact Phone Number
_____	_____
_____	_____
_____	_____

I, _____ (_____), have been
Relationship to Patient
informed that a copy of Ear Nose & Throat, P.C. Notice of Privacy Practice is posted in the office and a copy can be furnished to me upon my request.

Signature_____ Date_____