

ENT FACULTY PRACTICE

Please print clearly

Patient Age: _____ If Patient is a minor please indicate:
Mother's Name: _____ Father's Name: _____
Mother's Occupation: _____ Father's Occupation: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell#: _____

Patient DOB: _____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single ___Married ___Other

Email Address: _____

Emergency Contact: _____ Phone #: _____

Employer Name: _____

Address: _____

Primary Dr: _____ Referring Dr: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Fax#: _____ Fax#: _____

Pharmacy Name _____ Phone: _____

Address _____

Prescription Coverage _____ ID# _____ Phone# : _____

Insurance Information:

Primary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____

Policy Holder DOB _____ Policy Holder SS#: _____

Policy Holder Relation to Patient: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

***Patient Signature: _____ Date: _____

Name: _____ **D.O.B** _____

Have you ever had any of these medical problems in the **PAST** (please check all that apply)?

Check Here, If No Past Medical Problems.

CARDIOVASCULAR: <input type="checkbox"/> NONE	<input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack
EYE/EAR/NOSE/THROAT: <input type="checkbox"/> NONE	<input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Tinnitus	<input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Recurrent Acute Tonsillitis <input type="checkbox"/> Vertigo
GASTROINTESTINAL: <input type="checkbox"/> NONE	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hernia (Hiatal)	<input type="checkbox"/> GERD (Gastroesophageal Reflux)
PULMONARY: <input type="checkbox"/> NONE	<input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> COPD	<input type="checkbox"/> Tuberculosis
GENTOURINARY: <input type="checkbox"/> NONE	<input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Hernia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Acute Renal Failure
HEMATOLOGIC: <input type="checkbox"/> NONE	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anemia	
INFECTIOUS DISEASE: <input type="checkbox"/> NONE	<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Bronchitis	<input type="checkbox"/> Mononucleosis <input type="checkbox"/> Pneumonia	<input type="checkbox"/> STD Type: _____
METOBOLIC/ENDOCRINE: <input type="checkbox"/> NONE	<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Thyroid Deficiency (Hypothyroidism)	<input type="checkbox"/> Thyroid Excess (Hyperthyroidism)
CANCER: <input type="checkbox"/> YES <input type="checkbox"/> NO	Enter Type: _____	Enter Type: _____	Enter Type: _____
NEUROLOGIC: <input type="checkbox"/> NONE	<input type="checkbox"/> Migraines <input type="checkbox"/> Seizures	<input type="checkbox"/> Other Disorder (Parkinson's, Alzheimers, ALS, MS): Enter Type: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> Neuropathy
OBSTETRIC: <input type="checkbox"/> NONE	<input type="checkbox"/> Complications During Pregnancy	<input type="checkbox"/> Complications During Delivery	<input type="checkbox"/> Preterm Birth
PSYCHIATRIC: <input type="checkbox"/> NONE	<input type="checkbox"/> Adjustment Disorder - Anxiety	<input type="checkbox"/> Major Depressive Disorder	
AUTOIMMUNE DISEASE: <input type="checkbox"/> NONE	Type _____		

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: <input type="checkbox"/> NONE

For any indicated Medical problems was surgery performed (fill in as much information as possible)? NONE

Date or Age: _____ Facility: _____ Treatment/Surgery: _____ Physician: _____

Date or Age: _____ Facility: _____ Treatment/Surgery: _____ Physician: _____

Date or Age: _____ Facility: _____ Treatment/Surgery: _____ Physician: _____

Name: _____ D.O.B _____

Medications:

List medications and vitamins that you take on a regular basis. NONE
(Please include Supplements, Homeopathic, Herbal and Over The Counter Medicines)

Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____

Allergies:

- Check Here, If No Known **Food Allergies.**
- Check Here, If No Known **Environmental Allergies.**

Do you have any of the following **Food or Environmental Allergies** (please check all that apply)?

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Beans	<input type="checkbox"/> Dairy	<input type="checkbox"/> Dogs <input type="checkbox"/> Cats
<input type="checkbox"/> Eggs	<input type="checkbox"/> Feathers	<input type="checkbox"/> Seafood (fish)	<input type="checkbox"/> Latex
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Pollen	<input type="checkbox"/> Rag Weed	<input type="checkbox"/> Other:
<input type="checkbox"/> Dustmites	<input type="checkbox"/> Trees/Grass	<input type="checkbox"/> Mold	

Check Here, If No Known **Drug Allergies.**

Do you have any of the following **Drug Allergies** (please check all that apply)?

<input type="checkbox"/> Ace Inhibitors	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Macrolides (Mycin Drugs)
<input type="checkbox"/> Sulfas	<input type="checkbox"/> IVP Dye, Iodine Containing	<input type="checkbox"/> NSAIDS (Motrin/Advil/Ibuprofen)	<input type="checkbox"/> Penicillin's
<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Have you ever had any problems or reactions to Anesthesia? NO YES If yes, please explain: _____

Social History:

Do you, or have you ever smoked? N/A

<input type="checkbox"/> I've Never Smoked	<input type="checkbox"/> Currently Smoke Cigars
<input type="checkbox"/> A Former Smoker - Pack(s)/Day Age Started: _____	Age Stopped: _____ Year Quit: _____
<input type="checkbox"/> Currently Smoke Cigarettes - Pack(s)/Day	<input type="checkbox"/> Currently Smoke a Pipe

Do you drink alcohol (please check)? N/A

<input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Drink Daily
<input type="checkbox"/> Occasionally (Social)	<input type="checkbox"/> Former Alcohol Intake, None For _____ Years.

Do you use recreational drugs? Yes No N/A

<input type="checkbox"/> Amphetamines Dates of use _____ to _____	<input type="checkbox"/> Intravenous Drugs Type: _____ Dates of use _____ to _____
<input type="checkbox"/> Barbituates Dates of use _____ to _____	<input type="checkbox"/> Marijuana Dates of use _____ to _____
<input type="checkbox"/> Cocaine/Crack Dates of use _____ to _____	<input type="checkbox"/> MDMA (Ecstasy) Dates of use _____ to _____

Are you presently or have you ever been exposed to a second hand smoke hazard?

<input type="checkbox"/> No	<input type="checkbox"/> Yes – (circle one, or both) Presently Past
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Do you consume caffeine?

<input type="checkbox"/> Yes (Circle): Coffee Tea Other Beverage(s)	<input type="checkbox"/> No
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What is Your Water (H₂O) Intake? If so, how much...

_____ (Circle One): Glasses/Ounces Per Day/Unknown
--

Name: _____ D.O.B. _____

Family History (Please Place Check Marks Below):

If history unknown check here

<u>RELATION:</u>	C H I L D	P A R E N T	S I B L I N G	G R A N D P A R E N T	O T H E R R E L A T I V E
<u>FAMILY HISTORY OF:</u>					
ADD-Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines (Common)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enter if anyone in your family (child, parent, grandparent, sibling, other relative) has had the **Same or Similar ENT (ear, nose, throat) related problem as the reason for your visit:** NONE

Problem: _____ Family Member(s): _____

Problem: _____ Family Member(s): _____

Problem: _____ Family Member(s): _____

Name: _____ D.O.B. _____

“Review of Systems”:

Put a check next to the **medical issues you CURRENTLY have**, fill in “Other”, or “No Problems”:

Constitutional: No Problems Fever Chills Night Sweats Dizziness

Other: _____

Cardiovascular: No Problems Chest Pain Swelling of Extremities High Blood Pressure

Other: _____

Endocrine: No Problems Thyroid Problem Diabetes

Other: _____

Eyes: No Problems Blurry Vision Double Vision Itchiness Blindness Photophobia

Other: _____

Gastrointestinal: No Problems Nausea Vomiting Bleeding Liver Problem Diarrhea

Other: _____

Respiratory: No Problems Asthma Pneumonia Cough Sputum Wheezing Tuberculosis

Other: _____

Genitourinary: No Problems Bleeding Burning Kidney Stones Prostate Problem

Other: _____

Hematologic: No Problems Easy Bruising Anemia Clotting Problem

Other: _____

Immunologic: No Problems HIV Positive AIDS

Other: _____

Lymphatic: No Problems Nodes Lumps

Other: _____

Musculoskeletal: No Problems Pain Swelling Weakness Stiffness Arthritis

Other: _____

Neurological: No Problems Numbness Memory Problems Vertigo

Other: _____

Ob/Gyn (females only): No Problems Pregnant Irregular Periods Discharge

Other: _____

Psychiatric: No Problems Depression Anxiety Hallucinations Suicidal Tendency Drug Addiction

Other: _____

Skin: No Problems Rash Lesion Pain

Other: _____

**ENT FACULTY PRACTICE, LLP
OFFICE POLICY
PATIENT FINANCIAL RESPONSIBILITY**

I agree to assume all financial responsibility for the medical care, treatment and other related services provided to myself and/ or to

_____ **by ENT Faculty Practice, LLP.**

_____ **(Name of Patient)**

If my co-payment is not paid at the time of my visit I am responsible for an administrative charge of \$20.00 in addition to my co-pay.

If payment is not made today, I understand that any balance owed must be paid full within 30 days from the date of my bill; If payment is made later than 30 days from the date of my bill, I understand that I am responsible for interest charges, which will accrue at a rate of 1.5% per month.

I am responsible for the collection fees, attorney's fees and any other costs associated with collecting this bill or any of my bills in the future. If I fail to remit any fees due to ENT Faculty Practice, LLP. If a check I issue to ENT Faculty Practice, LLP is returned unpaid by my bank for any reason, I agree to be responsible for a returned check charge of \$25.00.

I am aware that ENT Faculty Practice, LLP cannot accept the responsibility of collecting insurance benefit. I am directly responsible to ENT Faculty Practice, LLP for payment of all balances due regardless of insurance coverage, ENT Faculty Practice, LLP agrees to complete routine medical insurance claims forms at no additional charge.

_____ **Signature of Responsible Party**

_____ **Print Name of Responsible Party**

_____ **Print Patients Name**

_____ **Date**

**ENT FACULTY PRACTICE, LLP
ASSIGNMENT OF BENEFITS AND GUARANTEE OF
PAYMENT**

I hereby authorize and direct my insurance carrier to make payment directly to ENT Faculty Practice, LLP and hereby assign to said office and any and all rights, title and interest I have in insurance proceeds or benefits payable to me or on my behalf for services rendered to me by said medical office.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE NAMED MEDICAL OFFICE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR ON MY BEHALF.

I hereby authorize and direct the above named medical office and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance and other payers.

Date

Time

Signature of patient/responsible person

Witness

IF PERSONS OTHER THAN THE PATIENT SIGNS, INDICATE RELATIONSHIP TO THE PATIENT AND REASON FOR LACK OF PATIENTS SIGNATURE.

PATIENT HIPPA AWARENESS

With my permission, ENT Faculty Practice, LLP may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ENT Faculty Practice, LLP Notice of Privacy Practices for more complete description of such uses and disclosures.

It is my responsibility to review the Notice of Privacy Practices prior to signing this consent. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of ENT Faculty Practice, LLP, may call my home or other designated locations and leave a message on my voice mail or in person in reference to any item that assists the practice in carrying out TPO , such as appointments, reminder cards, and patient statements. I have the right to request the ENT Faculty Practice, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does it is bound to this agreement.

By signing this, I am allowing ENT Faculty Practice, LLP to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

**SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN
GUARDIAN**

**PRINT NAME OF PATIENT
PARENT OR LEGAL**

PATIENT'S NAME: _____

DATE: _____

ENT Faculty Practice, LLP
OFFICE REFERRAL POLICY
PLEASE READ AND SIGN

Please initial box 1 or 2 below:

1. I am aware that the terms of my insurance contract requires me to obtain a referral form from my participating primary care physician before receiving the services I seek at our practice.

***Please note that a referral cannot be backdated.**

2. To my knowledge my insurance company does not require a referral for services provided by a specialist. If my insurance company denies my claim stating that a referral is necessary, I am aware that I will be financially responsible for the provider's full charges for services provided to me or my dependant.

*** Please note that a referral cannot be backdated.**

If you have any questions about the referral process under your benefit contract or are not sure whether a referral is required before receiving the services you seek today, please contact your insurance customer service at the phone number listed on the back of most insurance cards.

By signing below I am acknowledging my consent to pay directly to the provider all charges arising from my or my dependent's office visit today.

Print name of patient and legal guardian (if applicable)

(Patient/Legal Guardian)

Contract Holder's Name _____

Contract Holder's ID No. _____

Accept and agreed _____

Witness _____