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: _____ Apt/Unit#: _____

City:_____State: _____Zip Code: _____

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

Patient DOB:_____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single __Married __Other

Language: (please circle one) Chinese English French German Italian Japanese Portuguese Russian Spanish

Race: (please circle one) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander Other Race White

Ethnicity:(please circle one) Hispanic or Latino Not Hispanic or Latino Unknown

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# :_____

*****Patient Signature:_____ Date:_____**

ENT FACULTY PRACTICE

Please print clearly

Please check appropriate box and sign below:

☐ There has been NO change in my insurance since my last visit.

☐ There has been a change in my insurance. Please update information.

Name:_____ DOB:_____

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:_____**

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

EAR•NOSE•THROAT ENT
FACULTY PRACTICE
entfaculty.com

Health History Questionnaire- New Adult Patient

Please fill this form out as completely as possible and bring this to your appointment.

Date of Appointment: _____(mmlddlyyyy)

Referring MD: _____

Primary MD: _____

Preferred Pharmacy (Name, Street, City): _____

What is the reason for your visit (chief complaint)? _____

Past Medical History (Circle any medical problems you have had) ▢ Check here if no past medical problems.

Cardiovascular	Coronary Artery Disease; Congestive Heart Failure; Elevated Cholesterol; High Blood Pressure; Heart Attack; Arrhythmia (palpitations)
Eye/Ear/Nose/Throat	Cataracts; Glaucoma; Chronic Ear Infections; Hearing Loss; Tinnitus; Vertigo; Nasal Polyps; Sinus Problems; Recurrent Tonsillitis
Gastrointestinal	Hepatitis; Liver Disease; Cirrhosis; Hernia (hiatal); GERD (gastroesophageal reflux)
Pulmonary	Asthma; COPD; Tuberculosis; Sleep Apnea
Genitourinary	Enlarged Prostate; Hernia (inguinal); Kidney Stones; Acute Renal Failure; Chronic Renal Failure
Hematologic	Bleeding/Clotting Disorder; Anemia; Deep Venous Thrombosis
Infectious Disease	HIV/AIDS; Mononucleosis; STD (Type _____); Bronchitis; Pneumonia
Metabolic/Endocrine	Diabetes Mellitus (Type _____); Hyperthyroid (high thyroid); Hypothyroid (low thyroid)
Neurologic	Migraine; Dementia (Type _____); ALS; MS; Stroke; Seizures; Neuropathy
Psychiatric	Anxiety; Depression; Substance Abuse
Rheumatologic	Rheumatoid Arthritis; Autoimmune Disease (Type _____)
Cancer	Type(s): _____
Other (specify)	

Past Surgical History (Check any surgeries you have had and indicate date of surgery if known) ▢ Check here if no past surgeries.

▢ Tonsillectomy
▢ Adenoidectomy
▢ Facial Cosmetic Surgery (Type _____)
▢ Facial Fracture Surgery (Type _____)
▢ Ear Surgery (Type _____)
▢ Sinus Surgery
▢ Heart Surgery
▢ CABG (Heart Bypass)
▢ Heart Valve Replacement
▢ Cholecystectomy (Gall bladder removal)
▢ Hysterectomy
▢ Joint Replacement
▢ Hernia Repair
▢ Brain Surgery
▢ Appendectomy

Other: _____

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

Medication List

Please list the names of any medications that you are currently taking below. Please indicate the correct dosage and frequency (if known). Include supplements, herbals and over the counter medications. If you are unsure, ask your clinician.

Medication Name	Dose/Frequency (how often taken)

Allergies / Adverse Reactions

▢ No known medication allergies.
▢ No known food allergies.
▢ No known environmental allergies.

Please indicate any medications, foods, etc. to which you have had an allergic or bad reaction. Please include the reaction to the food or medication, if known (e.g. hives, difficulty breathing, rash, etc.)

_____

_____

_____

Have you ever had any problems or reactions to anesthesia? ▢ No ▢ No prior anesthesia ▢ Yes (please explain below)

_____

Social History

What is your most recent occupation (if age 18 years or older)? _____

Do you, or have you ever, smoked?
▢ Never Smoked
▢ Former Smoker
▢ Current Smoker
▢ Exposed to Second Hand Smoke (Current or Past?)

If you currently smoke or formerly smoked:
Age started smoking: _____
Age quit smoking: _____
Packs per Day: _____
Other smokeless tobacco products used: _____

Do you drink alcohol?
▢ Never
▢ Rarely
▢ Occasionally (socially)
▢ Daily
▢ Former alcohol intake; none for _____ years

Do you, or have you ever, used recreational drugs?
▢ Never
▢ Former user (Quit _____)
▢ Current user (Please indicate type and amount below)
_____
_____

Do you consume caffeine: ▢ No ▢ Yes (Type and amount:_____)

What is your daily water intake? _____

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

Family History

Please check below any problems that family members have had. If known, please state age at which they had a problem.

▢ I was adopted and do not know my family history.

	Mother	Father	Sibling	Child	Grandparent	Other Relative
Alive? (yes, no or N/A)						
Anesthesia Problems						
Alcoholism						
Bleeding Disorder						
Cancer (Type?)						
Heart Disease						
Hearing Loss						
Migraine						
Stroke						
Other						

Review of Systems Please circle any current problems/symptoms or write in unlisted problems/symptoms:

Constitutional	fevers; chills; night sweats; dizziness; fatigue; weight loss
Cardiovascular	chest pain; swelling of extremities; high blood pressure; irregular heart beat; syncope
Endocrine	diabetes; thyroid disease; cold intolerance; poor wound healing
Eyes	blurry vision; double vision; itchiness; blindness; photophobia
Gastrointestinal	nausea; vomiting; bleeding; liver disease; diarrhea
Respiratory	asthma; pneumonia; cough; sputum; wheezing; tuberculosis; coughing up blood; shortness of breath
Genitourinary	bleeding; burning with urination; kidney stones; prostate problem; kidney disease
Hematologic	easy bruising; anemia; clotting disorder; deep venous thrombosis
Immunologic/Lymphatic	HIV positive; AIDS; immunosuppressed; swollen lymph glands; lumps
Musculoskeletal	pain; swelling; weakness; stiffness; arthritis; autoimmune disease
Neurological	numbness; memory problems; vertigo; stroke; seizures; paresthesias (burning or prickling sensation)
OB/Gyn (females only)	pregnant; irregular periods; discharge
Psychiatric	depression; anxiety; hallucinations; suicidal tendency; drug addiction; eating disorder
Skin	rash; lesion; pain

Person completing these forms (print): _____ Date: _____

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

Financial Responsibility - Assignment of Benefits - Guarantee of Payment
Patient Release of Medical Information For In Network Insurance Plans
With our Providers at ENT Faculty Practice, LLP

I agree to assume all financial responsibility not covered or paid for by my insurance for the medical care, treatment and other related services provided to (Patient Name) _____ for services at ENT Faculty Practice, LLP.

1. **Patient Information/Proof of Insurance**: At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for full payment of services rendered if your insurance does not pay.
2. **Coverage changes**: If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.
3. **Per your insurance plan, patient is responsible for any and all co-payments, deductibles, and coinsurances.**
4. **If your Insurance Plan Requires Referrals for Specialists**, you must provide Referrals prior to the date of your appointment with our doctors**. Patient will not be seen without a Referral if your plan requires a Referral.**
5. It is the policy of the practice to treat all patients in an equitable fashion related to account balances. **The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks or the following credit cards: Visa, MasterCard and Discover. If Copay not paid at time of visit, patient will not be seen. Certain plans have additional copays on diagnostic tests and procedures and you will be billed for these additional copays after your insurance carrier pays your claim if they were not paid at time of visit.
6. **Missed appointments:** Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient will be charged $35.00, as set by the Practice, for failure to show. These charges will be your responsibility and must be paid before being scheduled for another appointment.
7. **Non-covered services**: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid. If you are a Medicare Participant, you are also required to sign the Medicare Agreement Payment form which is attached. I am aware that whether ENT Faculty Practice, LLP does or does not participate with my insurance, any charges not covered are my responsibility. Once insurance payments are made, any balance stating "patient due" on the explanation of benefits is also my responsibility. This may include multiple co-pays per visit, deductibles and co-insurance. If the insurance company denied the claim, it is the patient's responsibility to pay ENT Faculty Practice, LLP.

Initials

8. **Self-pay patients are expected to pay for services in FULL at the time of the visit**, unless special arrangements have been made.
9. **If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.** We will supply you with an invoice that you can submit to your insurance for reimbursement.
10. **Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 30 days will be charged a $20 re-bill fee for each 30-day cycle for up to (3) billing cycles – 90 days. After such time if balance remains unpaid your account will go to our Attorney or Collection Agency for collection follow-up. This debt will be reported to Credit Bureaus.** In the event your account is sent to a collection agency, you will be liable for your total account balance and you will be liable for an additional 30% collection/attorney fee plus filing and processing costs with local court system.
11. **For scheduled appointments, prior balances must be paid at the time of the visit or patient will not be seen.**
12. **A $50 fee will be charged for any checks returned for insufficient funds and additional late fees will apply.**
13. **I hearby authorize and direct my insurance carrier to make payment directly to ENT Faculty Practice, LLP and hereby assign to said office any and all rights, title, interest I have in insurance proceeds or benefits payable to me or on my behalf for services rendered to me by said medical office.**
14. **Patient Release of Medical Information: The Physicians and Surgeons, and/or their staff of ENT Faculty Practice, LLP may release verbally or in writing medical information to: Pharmacy for prescribing medications, Insurance carrier for authorizations for services and performing laboratory tests, or other tests admitting patient to hospital or providing medical care, Releases to Return to Work, Insurance Forms to Medical Coverage or Workers Compensation, Letters for Medical reasons for doctors' appointments or other reasons leading to missed days of work and may discuss patients' medical condition with other physicians involved in patient care.**
15. **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 voicemail or in person in reference to any item that assist 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 disagreement. 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.**

By Signing Below, I acknowledge items 1-15 above and give my consent to pay directly to the provider all charges arising from my or my dependents services received.

_____	_____	_____
Signature of Patient, Parent, or Legal Guardian	**Print Name of Patient, Parent, or Legal Guardian**	**Patients' Name**

Date:_____