ASSOCIATES OF EAR, NOSE & THROAT SURGERY

Please notify our front office as information changes so that our records will be accurate.

First Name_____ Full Middle Name_____ Last Name_____

Address_____City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (____)_____

Birth Date _____ Social Security _____ ☐Male ☐Female ☐Married ☐Single

Race: _____ Ethnicity:_____

Primary Language: _____ Occupation _____

How did you hear about our office?_____

Referring Physician_____ Phone_____ Fax_____

Address_____

Primary Care Physician_____ Phone_____ Fax_____

Address_____

Other Physician_____ Phone_____ Fax_____

Address_____

*Regular Pharmacy Name_____ Address_____Phone_____

Primary Insurance_____

☐ Spouse's Insurance ☐ Parent's Insurance

Insured Name_____

Birth Date_____ Social Sec_____

Home (____)_____ Work(____)_____

Insured's Employer _____

Secondary Insurance _____

☐ Spouse's Insurance ☐ Parent's Insurance

Insured Name_____

Birth Date_____ Social Sec_____

Home (____)_____Work(____)_____

Insured's Employer _____

Phone (972) 420-7212 Fax (972) 420-8812
www.AssociatesofENT.com

Name: _____ **Date of Birth:** _____ **Today's Date**_____

Patient Health History

Chief Complaint

Medical reason for today's visit?_____

Date Problem Started (onset)___/___/

Past History

Have you ever had the following? (Circle "yes" or leave blank if no or uncertain)

Mumps…….	Yes	Heart Murmur……..	Yes	Hepatitis…….	Yes
Measles……...	Yes	Rheumatic Fever……	Yes	Kidney Disease…….	Yes
Chickenpox…….	Yes	Heart Attack……	Yes	Thyroid Disease……	Yes
Scarlet Fever……..	Yes	Emphysema/COPD …..	Yes	Diabetes……	Yes
STD …….	Yes	Tuberculosis……..	Yes	Depression…….	Yes
Glaucoma……	Yes	Reflux…….	Yes	Anxiety……	Yes
Migraine Headache…...	Yes	Ulcer……...	Yes	Cancer……	Yes
Seizures……..	Yes	Liver Disease……	Yes		
Stroke……..	Yes				
Anemia……	Yes				
High Blood Pressure…..	Yes				
Atrial Fibrillation …….	Yes				

Please list location and year.

_____

_____

Please list any other prior major illness (include surgeries in next section) and/or injuries (use a separate sheet, if necessary):

1_____ 4_____

2_____ 5_____

3_____ 6_____

Surgeries/Hospitalizations (use a separate sheet, if necessary): Physician/Hospital Year

1_____ _____ _____

2_____ _____ _____

3_____ _____ _____

4_____ _____ _____

5_____ _____ _____

Do you or any of your family members have a tendency toward easy bleeding or bruising?……Yes

If yes, please describe_____

Have you or any of your family members ever had problems with anesthesia?……..Yes

Environmental Allergies Suspected (i.e. dust, pollen, ect.)……...Yes

Tested by Dr_____date tested_____

Allergy shots from _____ to _____

List Current Medications: (Include: herbal, alternative, and over-the-counter) and dose: (For example, Claritin 10mg, 2 tabs once daily)

1_____ 6_____

2_____ 7_____

3_____ 8_____

4_____ 9_____

5_____ 10_____

DO YOU TAKE ASPIRIN? YES OR NO ARE YOU UNDER THE CARE OF A CARDIOLOGIST?

Please list any medication allergies or side effects: (i.e., rash)

1_____ 4_____

2_____ 5_____

3_____ 6_____

Family History

Family Member	Alive/Deceased	Age	Medical Conditions or Cause of Death
Grandmother (mom's)	A D		
Grandfather (mom's)	A D		
Grandmother (dad's)	A D		
Grandfather (dad's)	A D		
Father	A D		
Mother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		

Social History

Have you ever or do you use tobacco? Yes No

( )Cigarettes up to____packs per day for____years Year quit _____

( )Pipe up to____bowls per day for____years Year quit _____

( )Cigar up to____cigars per day for____years Year quit _____

( )Chew up to____pouches per day for____years Year quit _____

( )Dip up to____cans per day for____years Year quit _____

Have you ever consumed or do you consume alcohol?

( )No, never or rarely

( )Yes, Type_____Quantity?_____

For example: One 6pack per day/week/year

Are you currently having problems with:

Ear, Nose, Throat and Mouth

Nasal congestion ..…….…… Yes
Hearing aids ……...…… Yes
Balance problems ……..……. Yes
Decreased hearing ..……. Yes
Decreased sense of smell ....…..…….. Yes
Difficulty swallowing ..……..…… Yes
Sore throat ……..Yes
Hoarseness ……Yes
Mouth pain ……..Yes
Nasal drainage …… Yes
Ear pain ….…… Yes
Ear drainage ……..... Yes
Ringing in the ears……..Yes

ASSOCIATES OF EAR, NOSE & THROAT SURGERY

Patient Consent for the Disclosure of Information

- I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.
- I understand that records pertaining to the diagnosis and/or treatment of AIDS, HIV testing, psychiatric illnesses, and alcohol or chemical abuse and dependency cannot be disclosed without my written authorization, except otherwise provided by law.
- I understand that a photocopy or facsimile of this authorization is valid as the original.
- I authorize the release of any medical, billing or other information necessary to process claims on my behalf**. I am aware that I am fully responsible for all lawful debts incurred by myself or dependent for services received from Associates of Ear, Nose & Throat Surgery whether covered by insurance or not.**
- I agree to pay for any outstanding balance, co-pay, deductible and/or co-insurance at the time services are rendered. Should my account become delinquent, I agree to pay necessary collection fees of 35% of the outstanding debt.
- I authorize Associates of Ear, Nose & Throat Surgery to share any information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation and compliance with all federal and state laws.
- By providing my cell number, I consent to permission of text/sms messages for the purposes of HIPPA compliant messages, including appointment information. I understand that my number will not be sold or used for marketing purposes.

My consent is given and I understand that I may revoke this authorization at any time by doing so in writing. Any disclosures given prior to any revocation will be permissible. Please refer to the HIPAA Notice of Privacy Practices for full information.

CANCELLATION POLICY

Our doctors are committed to providing comprehensive & excellent care to our patients.
Unfortunately, when one patient cancels without giving adequate notice, they prevent another patient from being seen.
Our cancellation fees are as follows:

NO SHOW/CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE: $25.00
SURGERY CANCELLATIONS WITH LESS THAN 5 DAYS NOTICE: $350.00

Name of Patient

✘

Signature of Patient, Parent or Legal Guardian **Date**

(must be over 18 to sign)

☐ If the office attempts to contact you and a message is taken by an answering machine, voicemail **or** another person, it is acceptable for us to leave detailed message regarding lab tests and results.

PLEASE INITIAL

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ASSOCIATES OF EAR, NOSE & THROAT SURGERY

Release to discuss information in patient's absence

PATIENT'S NAME_____ DATE OF BIRTH_____

If Patient is under 18:

Parent or Legal Guardian's* Name _____ Phone (_____)_____

Parent or Legal Guardian's* Name _____ Phone (_____)_____

**If legal Guardian, guardianship paperwork must be presented.*

Please complete the following information if you would like to give permission for someone else to discuss medical care and/or obtain medical treatment in your absence. A minor must be accompanied by the parent, legal guardian or one of the adults listed below in order to be seen by the physician. This information will be kept in the patient's chart. Please inform the receptionist when this information needs to be updated.

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

✘_____ _____

Signature of Patient/Guardian (*must be over 18 to sign)* Date

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Associates of
EAR, NOSE & THROAT
Surgery

Specialist Procedure Notification

Please note that because we are a specialist office, some procedures done during a normal office visit are defined by the American Medical Association as *surgical* procedures. These procedures are often considered "special" procedures by your insurance company and **may be covered at a different rate, through a deductible or patient responsibility. We will not be able to determine ahead of time the specific procedure that may need to be conducted in order to diagnose our patients during the exam.** Some of these procedures may be:

- Hearing testing
- Looking into the nasal passage through a lighted scope
- Ear wax removal
- CT Scans

Please be advised that your visit may incur some of these charges and that you may owe more than your copay once all insurance has been paid. This notice is a courtesy notification informing patients of typical insurance patterns.

_____

Name of Patient **(please print)**

_____

Signature of Patient, Parent or Legal Guardian
(must be 18 or older to sign)

_____

Date

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