EAR, NOSE & THROAT
ASSOCIATES

Patient Information (Adult)

Patient's Legal Name _____ Date of Birth _____ Gender ☐ M ☐ F

Address _____ SSN or ID# _____

Relationship _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Occupation _____

Work Phone _____

Emergency Contact _____ Emergency Contact Phone # _____

Emergency Contact Relationship _____

Guarantor Information (person responsible for the bill)

Name _____ Date of Birth _____ Gender ☐ M ☐ F

Address _____ SSN or ID# _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Occupation _____ Work Phone _____

Insurance Information

Primary Insurance _____ Policy ID # _____

Group # _____ Group Name _____

Policy Holder _____ SSN _____

Relationship _____ Date of Birth _____

Secondary Insurance _____ Policy ID # _____

Group # _____ Group Name _____

Policy Holder _____ SSN _____

Relationship _____ Date of Birth _____

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Patient History

Name _____ Age _____ Date of Birth _____ Race _____

Referring Physician _____ Primary Care Physician _____

Pharmacy of Choice (name & location) _____

Reason for Your Visit _____

Please answer all questions as thoroughly as possible

1. Are you allergic to any medication? ☐ Yes ☐ No If so, please list all drug allergies _____

_____

2. Are you currently taking any medications? ☐ Yes ☐ No If so, please list all current medications _____

_____

3. Do you have any existing medical conditions? ☐ Yes ☐ No If so, please list ALL _____

_____

4. Have you ever had a surgical procedure? ☐ Yes ☐ No If so, please list and date all _____

_____

5. Does anyone in your family have any of the following? ☐ None ☐ Do Not Know

☐ Allergies	☐ Asthma	☐ Hearing Loss	☐ Throat Cancer
☐ Diabetes	☐ Heart Disease	☐ Anesthesia Difficulty	☐ Bleeding Problems

☐ Other _____

6. Are your immunization records up to date? ☐ Yes ☐ No

7. Do you: ☐ Never Smoke

☐ Smoke Every Day _____ packs per day for _____ years

☐ Smoke Some Days _____ packs per day for _____ years

☐ Former Smoker Date Quit _____

8. Do you drink alcohol? ☐ Yes ☐ No

If yes, frequency is: ☐ Socially ☐ Minimally ☐ Infrequently ☐ Frequently

9. Any illicit drug use? ☐ Yes ☐ No Type _____

Patient Signature _____ Date _____

7001 Heritage Village Plaza, Suite 170, Gainesville, VA 20155

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Review of Systems

Name _____ Date of Birth _____

Are you experiencing any of the following?

GENERAL	☐ Pregnant	☐ Fever
☐ Chills/Sweats	☐ Fatigue/Malaise	☐ Sleep Problems
☐ Weight Gain	☐ Weight Loss	☐ Hoarse Voice
☐ Speech Delay	☐ Unusual Bleeding	
EARS	☐ Ear Pain	☐ Hearing Loss
☐ Tinnitus/Ringing Noise	☐ Ear Fullness/Pressure	☐ Ear Itching
☐ Earwax	☐ Ear Drainage	
NOSE	☐ Nasal Obstruction	☐ Nasal Congestion
☐ Runny Nose	☐ Post Nasal Drip	☐ Nosebleed
☐ Facial Pain	☐ Seasonal Allergies	
THROAT	☐ Foreign Body Sensation	☐ Hoarseness
☐ Snoring	☐ Throat Pain/Soreness	☐ Swallowing Difficulty
☐ Heartburn		
SKIN	☐ Suspicious Lesions	☐ Excess Scarring/Keloids
☐ Rash	☐ Itching	☐ Ulcer/Growths
ALLERGY/IMMUNOLOGY	☐ Eczema	☐ HIV Exposure
☐ Hives	☐ Hay Fever	
NEUROLOGICAL	☐ Numbness	☐ Muscle Weakness/Paralysis
☐ Headache	☐ Fainting/Blackouts	☐ Seizures
BALANCE/VESTIBULAR	☐ Dizziness	☐ Vertigo
☐ Feeling Lightheaded	☐ Imbalance But Not Vertigo	☐ Motion-Provoked Dizziness
☐ Dizziness That is Positional	☐ Joint Problem/Arthritis	☐ Falling Episodes
EYES	☐ Eye Pain	☐ Vision Change
☐ Double Vision	☐ Discharge	☐ Light Sensitivity
☐ Itching/Irritation	☐ Excessive Tears	☐ Dry Eyes
NECK		
☐ Lump/Mass	☐ Thyroid Problem	☐ Neck Pain
RESPIRATORY	☐ Cough (Productive)	☐ Cough (Dry)
☐ Wheezing	☐ Sleep Apnea	☐ Shortness of breath

Patient Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ , was offered and:

☐ I have received a copy of the "Notice of Privacy Practices" for Ear, Nose & Throat Associates, PC.

☐ I have declined a personal copy of the "Notices of Privacy Practices" for Ear, Nose & Throat Associates, PC.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our offices, on our website, and copies are available at any time. I understand that I may ask questions of Ear, Nose & Throat Associates if I do not understand any information in the Notice of Privacy Practices.

I understand that I may access my medical records at any time and that I may copy and/or inspect my protected health information (PHI) to be used or disclosed in accordance with Ear, Nose & Throat Associates' policy. I understand that Ear, Nose & Throat Associates, PC may charge me for copies of such records or completion of medical record forms; however, a fee schedule will be provided to me. I understand that Ear, Nose & Throat Associates, PC has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Notice of Privacy Practices provides information about how Ear, Nose & Throat Associates may use and disclose my PHI. Disclosures may be made to family and friends related to my health. Ear, Nose & Throat Associates will only disclose information relevant to current treatment. By signing below I authorize Ear, Nose & Throat Associates, PC to only disclose health care information to the following individuals (list all that apply):

	In Person	By Phone
Spouse Name _____	☐	☐
Parent(s) Name _____	☐	☐
Sibling(s) Name _____	☐	☐
Other _____ (name) (relationship)	☐	☐

Expiration Date of Authorization: _____ /_____ /_____ OR ☐ until otherwise specified

Ear, Nose & Throat Associates has my permission to leave medical information or messages on my:

☐ Home answering machine _____ (home phone number)

☐ Cellphone voice mail _____ (cellphone number)

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship

EAR, NOSE & THROAT
ASSOCIATES

Consent for Treatment, Assignment of Benefits, Financial Policies

CONSENT FOR TREATMENT

I authorize Ear, Nose & Throat Associates to provide medical treatment to myself and/or my dependent.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Ear, Nose & Throat Associates for services provided under their care.

RELEASE OF MEDICAL INFORMATION

I authorize Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

COLLECTION OF CO-PAYS AND DEDUCTIBLES

I understand that per agreements with my insurance carrier, I am required to pay any applicable copayments at the time of service. I understand that I am responsible for any deductible and/or balance my plan indicates on their Explanation of Benefits. I acknowledge that balances are due within 30-60 days from the date of service. I understand that billing is handled through Professional Accounts Management Service. They are available Monday through Friday, from 8:00 am to 4:00 pm EST. I realize that I can reach them at 1.888.313.9539 for any billing inquiries I might have.

FINANCIAL RESPONSIBILITY

I understand that Ear, Nose & Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I understand that if I do not have insurance, payment is expected in full at the time of service, and prior to any procedure. Should collection proceedings or other legal action become necessary to collect an overdue account, I understand that Ear, Nose & Throat Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I understand and agree to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by Ear, Nose & Throat Associates. I understand and agree that should Ear, Nose & Throat Associates be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

REFERRALS/AUTHORIZATIONS

I understand that my insurance company may require that I obtain a referral from my physician prior to being seen by a specialist. I understand that it is my responsibility to obtain the referral and/or authorization prior to my visit.

MISSED APPOINTMENTS

I understand that Ear, Nose & Throat Associates requires at least 24 hours notice if I must cancel an appointment. I realize that failure to do so will result in a $50 “no show” fee. I understand that if I fail to cancel an appointment at least 24 hours in advance a second time, I will be charged a $75 “no show” fee. I understand that this fee will NOT be covered by my insurance policy.

RETURNED CHECKS

Our office will charge $25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Ear, Nose & Throat Associates will scan this document and destroy the original, and agree the scanned document is the same as the original.

Signature _____ Date _____

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