PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important informaton. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ First _____ MI _____

Sex ○ Male ○ Female Date of Birth: _____

Name of Primary Care Physician: _____

Pharmacy Preference (included location) _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ○YES ○NO, **If yes, please list below:**

Name of Medication	Type of Reaction				

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ○Yes ○No

If yes, please list type of problems:

_____

_____

_____

List any surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons?

If yes, list reason for hospitalizations

_____

_____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

Patient Name:
MRN:

ASSOCIATES IN ENT

PRIVACY POLICY

Federal regulations require physician practices to keep your medical information private. Associates in ENT has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. **All other releases of information have to be specifically authorized by you.** If you ask us to account for these releases of information, we will do so. You may also request and receive a copy of your medical records and ask questions about its content. (There will be a minor charge for copying). We will keep your medical record as long as you are a patient of the practice and for at least ten years after your last visit. We may occasionally send you information on new procedures and products that we offer.

I acknowledge that I have been informed about the privacy of my medical record. _____YES _____NO

RELEASE OF MEDICAL INFORMATION

The general policy of Associates in ENT is to release medical information only to patients and guardians. If you, the patient (or guardian), would like information to be released to anyone else (such as a spouse, parent, or close friend), you can identify other individuals in the section below. **We cannot release information, even to a spouse or parent of patients above the age of 18, unless we have permission to do so.** (You can modify this form at any time by adding or deleting the names of individuals who have access to your information.)

Relationship	Name	Contact #	Contact #

Please tell us the ways we can contact you.

- ☐ Home phone: _____
- ☐ Work Phone: _____
- ☐ Cell Phone: _____
- ☐ Email: _____

May we leave messages regarding: Appointments (Yes / No)? Test results (Yes / No)? Other Clinical Updates (Yes / No)?

_____ _____ _____

Patient name (please print) **Patient (or Guardian)** **Signature Date**

Patient Name: _____ Date of Birth: _____

ASSOCIATES IN E.N.T. HEAD & NECK SURGERY

Audio-Video Recording and Photography During Patient Visit

Associates in ENT shall take reasonable steps to protect patients, visitors, and workforce members from unauthorized photography, audio and/or video recordings, or other images.

Therefore, in order to facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), unauthorized photography, audio and/or video recordings of any type are prohibited on the premises.

By signing this notice, I acknowledge my understanding of Associates in ENT's policy prohibiting unauthorized photography and audio-video recordings during a patient's visit. Failure to comply with this notice could result in dismissal from the Practice.

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN DATE

Permission to Contact by Telephone or Text Message

I acknowledge and agree that Associates in Ear, Nose, Throat/Head & Neck Surgery, PLLC and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers.

I further agree that you may use any method of contact to these numbers, such as a dialing service or prerecorded message. I also agree that I will notify Associates in Ear, Nose, Throat/Head & Neck Surgery, PLLC if I have given up ownership or control of any such telephone number.

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN DATE

No Show Policy

This policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows delay the delivery of healthcare to other patients, some who are quite ill.

A "no show" is missing a scheduled appointment and/or you have not called within 24 hours to cancel.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

A charge of $50.00 will be assessed for each no show appointment.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility. To cancel or reschedule an appointment please call Associates in ENT at (423) 267-6738. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN DATE

ASSOCIATES IN ENT HEAD & NECK SURGERY

Personal Information:

Have we seen you or a family member before? YES NO If yes, Name: _____

Next Appt Date: _____ Account #: _____ SSN: _____

Last Name: _____ MI: _____ First Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Email _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Visit due to accident or work related injury? ☐ Yes ☐ No Work No: _____

Employer: _____ Full Time Student: ☐ Yes ☐ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other _____

Referring Physician's Name: _____ Phone No: _____

Primary Physician's Name: _____ Phone No: _____

May release medical information to: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group#: _____

Copay: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply. There will be a $25 service fee charged for NSF (insufficient funds) returned checks.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request. I understand that I am financially responsible for charges not covered by this assignment of benefits; and, should the account be referred for collection, I agree to pay 35% (thirty-five percent) collection and/or attorney's fees.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____