Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A.

TODAY'S DATE: ____________ **FOR TODAY'S VISIT YOU WILL BE PAYING:** ___Cash ___Check ___Credit Card

PATIENT INFORMATION:

Primary Care Physician:_________________________ Referring Physician: _____________________________

Last Name: __________________________First Name: ___________________ Middle Initial: ___ Age: ______

Social Security #: ____________________ Birthdate: ____/____/________Gender: M F X Marital Status: ___

Address: ____ Apt #: ________

City: _____________________________________ State: ________________________ Zip Code: ___________

Race: ______________________ Ethnicity: Hispanic / Non-Hispanic Language: ______________________

(Please circle one above)

Primary #: (_____) ________________ Cell #: (____) __________________

Work #: (____) ___________________ Home #: (____) _________________

Email: _________________________________

CONFIRMATION PREFERENCE:

☐ **TEXT**

☐ **CALL**

☐ **EMAIL**

PRIMARY INSURANCE CARRIER:

Insured's Name: ________________________________

Insured's Address: ______________________________

City: _________________ State: ____ Zip: _________

Insured's DOB: ______/_________/___________

SECONDARY INSURANCE CARRIER:

Insured's Name: ______________________________

Insured's Address: ______________________________

City: __________________ State: ____ Zip: _______

Insured's DOB: _______/________/________

Please submit insurance card for scanning. If no insurance card is available, please complete the following information:

Insurance Co: __________________________________ Insurance Co: ________________________________

Policy Number: ________________________________ Policy Number: ______________________________

PARENT/LEGAL GUARDIAN INFORMATION

If the patient is under the age of 18 or insurance is maintained by someone else; please complete the following:

If you are the grandparent or step-parent do you have legal guardianship of the patient? **Yes** **No**

****You must have court ordered paperwork on hand in order for the patient to be seen. Please submit paperwork so it may be filed in the chart and complete the information below:**

Name: ____________________________________ DOB: ___/____/____ SSN: ________________________

Address: __________________________________ City: ________________ State: _____ Zip Code: ________

Employer: ______________________________________ Work Phone: (_____)_________________Ext_______

Relationship: (please circle one) Mother Father Grandparent Step-Parent Legal Guardian Other ____________

H002-13 Aug 2018

OVER

AUTHORIZATIONS

I authorize the release of any medical information necessary to process the insurance claim form for services and/or quality assurance activity required by your plan or entity rendered by Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. I also request payment of government benefits to the party who accepts assignment. I do authorize payment of medical benefits to Tallahassee Ear, Nose & Throat Physicians/Providers.

FINANCIAL RESPONSIBILITY:

Patient/Responsible party shall pay to Tallahassee Ear, Nose and Throat such sums as are now or may become due for services rendered to the patient and for which the patient's health maintenance organization or insurer is not liable for payment for fees to TENT. Guarantor must sign for all minors or dependents. An administrative fee will be assessed should the account require collection efforts. The guarantee of the account hereby assumes full financial responsibility for payment for all medical services by the named patient in accordance with the terms as set forth in the Authorization above.

SIGNATURE: ____ (if patient is a minor or dependent, the Guarantor must sign here)

SIGNATURE: ____ DATE: __________________________________

RECEIPT OF PATIENT PRIVACY NOTICE:

A copy of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A has been made available to me as printed and/or posted in the office or available on the website for my review. My Protected Health Information may be used for treatment, payment and general practice operation. Beyond this, I may provide in writing a list of people who are authorized to have information medical or financial account information about me.

USE AND DISCLOSURE:

Patient/Provider relationship only begins at the time of the visit. No notes are reviewed prior to this visit. I understand that as part of my health care, Tallahassee Ear, Nose and Throat originates and maintains a paper and/or electronic record describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The use and disclosure of Protected Health Information for treatment, payment or operations is described in the Patient Privacy Notice. Your records may be shared with your other providers electronically or via phone, fax, or health information exchange.

SIGNATURE: ______________________________________ DATE: ______________________________________

DISCLOSURE OF OWNERSHIP:

Audiology Associates of North Florida, a division of Tallahassee Ear, Nose & Throat, is the only local audiology group able to coordinate your hearing services with physicians on-site. Please be advised that the following physicians own an interest in the audiology, allergy, and plastic services offered on site by Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: Duncan S. Postma, M.D., Spencer E. Gilleon, M.D., Adrian P. Roberts, M.D., Marie O. Becker, M.D., Joseph C. Soto, M.D and Graham T. Whitaker, M.D. We feel that the cooperation of the physicians and audiologists in our group is advantageous to our patients, but should you wish to have an alternative provider for these services, we will provide them upon request. In addition, these same physicians have ownership in the Red Hills Surgical Center and the CT scanner in the office. You may select any facility for your diagnostic study or where we are credentialed for surgical services upon your request.

I acknowledge this disclosure of ownership and my freedom to request any facility.

SIGNATURE: ______________________________________ DATE: ______________________________________

MEDICARE ASSIGNMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act U.S.C. 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits also apply.

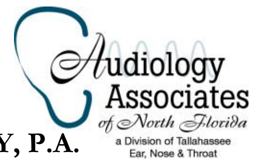
SIGNATURE: ______________________________________ DATE: ______________________________________

MEDICATION REPOSITORY:

Any pharmacy that participates with a central repository will have an updated list of your medications. In order to provide you with the best possible care, the providers would like your permission to access this repository.

SIGNATURE: ______________________________________ DATE: ______________________________________

PROCESSED BY _____



TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA

1405 Centerville Rd. Suite 5400
Tallahassee, FL 32308
(850) 671-5172

2625 Mitcham Drive
Tallahassee, FL 32308
(850) 877-4094

ADULT HEARING HISTORY

PATIENT NAME: ______________________________ **DOB:** __________ **DATE:** ______________

WHAT IS YOUR PRIMARY REASON FOR TODAY'S VISIT? ______________________________________

____

MEDICAL HISTORY

PLEASE MARK ALL RESPONSES THAT APPLY TO YOU:

AIDS/HIV	_____	HIGH BLOOD PRESSURE	____	MENINGITIS	____
ASTHMA	_____	HEAD INJURY	____	RHEUMATIC FEVER	____
CANCER (type__________)	_____	HEPATITIS, LIVER TROUBLE	____	STROKE	____
CONVULSIONS, EPILEPSY	_____	HIGH FEVER	____	THYROID DISEASE	____
DIABETES	_____	KIDNEY PROBLEMS	____	OTHER _____________	____
HEART ATTACK	_____				

MEDICATIONS

______ **None** ______ **List attached**

(Please make sure to include over-the-counter medications, vitamins and herbal remedies)

	Name	Dose		Name	Dose
1.	____________________	__________	**6.**	____________________	__________
2.	____________________	__________	**7.**	____________________	__________
3.	____________________	__________	**8.**	____________________	__________
4.	____________________	__________	**9.**	____________________	__________
5.	____________________	__________	**10.**	____________________	__________

ALLERGIES

______ **None** ______ **List attached**

	Allergy	Reaction
1.	____________________	__________
2.	____________________	__________
3.	____________________	__________
4.	____________________	__________
5.	____________________	__________

EAR RELATED SURGERIES AND DATES

	Surgery	Date
1.	____________________	________
2.	____________________	________
3.	____________________	________
4.	____________________	________
5.	____________________	________

SOCIAL HISTORY

SMOKE NEVER ____ CURRENTLY ____ PREVIOUSLY ____ NUMBER OF PACKS PER DAY? _____

DRINK ALCOHOL NEVER ____ CURRENTLY ____ PREVIOUSLY ____ NUMBER OF DRINKS PER DAY? _____

RECREATIONAL DRUG USE NEVER ____ CURRENTLY ____ PREVIOUSLY ____

HEARING

HEARING LOSS RIGHT ____ LEFT ____ NONE ____

WHEN DID YOU FIRST NOTICE A PROBLEM? ____

RINGING/SOUNDS IN THE EAR RIGHT ____ LEFT ____ NONE ____

IF YES, PLEASE DESCRIBE: ____

NOISE EXPOSURE:

MILITARY WORK	YES	____	NO	____	IF YES, HOW LONG? ____________________
FACTORY WORK	YES	____	NO	____	IF YES, HOW LONG? ____________________
FIRE GUNS	YES	____	NO	____	
WOOD WORKING	YES	____	NO	____	
LOUD MUSIC	YES	____	NO	____	
YARD EQUIPMENT	YES	____	NO	____	

DO YOU WEAR HEARING PROTECTION? NO _____ OCCASIONALLY ____ ALL THE TIME _____

FULLNESS/PRESSURE IN THE EAR RIGHT ____ LEFT ____ NONE ____

DIZZINESS YES ____ NO ____

WHEN DO YOU EXPERIENCE THE MOST TROUBLE HEARING? ____

DO YOU HAVE A FAMILY MEMBER WITH HEARING LOSS? YES ____ NO _____

IF YES, WHO? ______________________________________

IF YOU ARE IDENTIFIED WITH HEARING LOSS, ARE YOU READY FOR HELP? ________________________________

HAVE YOU EVER WORN HEARING AIDS? YES _____ NO _____

IF HEARING AIDS ARE RECOMMENDED, ON A SCALE OF 1 TO 10, ARE YOU READY TO PURSUE HEARING AIDS AT THIS TIME?

NOT READY 1 2 3 4 5 6 7 8 9 10 START NOW

HOW DID YOU HEAR ABOUT OUR CENTER? FRIEND ___ DOCTOR REFERRAL ___ NEWSPAPER ___
TV AD ___ RADIO ___ SEMINAR ___ TELEPHONE BOOK ___
OTHER: ___________________

I have completed this medical/audiological history form and to the best of my knowledge it is complete and accurate. I understand that this document will be used for medical decision-making.

____ ________________________

Patient Signature Date

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
www.tallyent.com

Consent to Use or Disclose Information for Treatment, Payment of Healthcare Operations

I accept the terms of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. made available to me as printed and/or posted in the office or available on the website for my review. Protected Health Information may be used for treatment, payment and general practice operation.

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, postcards, emails, text messages, voicemails, billing statements or communication through the secure patient portal. I acknowledge that Email, voicemail and cell phones are not secure. It is my responsibility, as the patient, to provide accurate and current demographic information including mailing address, phone numbers and private personal email address for communication through the portal.

I understand that medical and financial information may be used by Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. for treatment, payment and normal operation of business. Beyond this, I give permission for my medical files or financial account to be discussed with the people I list on this form.

For patients under the age of 18, a parent or legal guardian must be listed on this form with all permissions given to be authorized for subsequent appointments in our office.

_______________________________________ _______________________
Patient's Name Patient's Date of Birth

****

•Name: _______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: _______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: _______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: _______________________________DOB: ___/___/___ [ ] Medical [ ] Financial [ ] Emergency
Phone: _____________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

I accept the terms of the Patient Privacy Notice. I consent to the Use or Disclosure of Protected Health Information (PHI) described above for the purpose of treatment, payment or healthcare operations. I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer.

____

Patient Signature or Guardian Signature Required

INTERNAL USE ONLY: ______________________________ ____________________
Employee Signature Date Names Entered