

# 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 \_\_\_\_\_

## **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.

**Please be aware that collections made by our office staff at the time of check-out are only an estimate for services rendered. Our policy is to bill and collect any balances due for services rendered by Tallahassee Ear, Nose and Throat.**

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.

## **USE AND DISCLOSURE:**

Patient/Provider relationship only begins at the time of the visit. No notes are reviewed prior to this visit. If you are scheduled with an Advanced Practice Registered Nurse in our office, you understand that they are not a physician and work with the support of the physicians in our practice. 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: \_\_\_\_\_

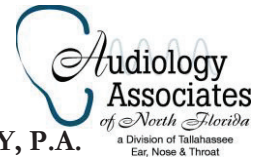
## **MEDICATION REPOSITORY:**

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: \_\_\_\_\_



**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 _____	RHEUMATIC FEVER _____
ASTHMA _____	HEAD INJURY _____	SINUS PROBLEMS _____
AUTOIMMUNE DISORDER _____	HEART ATTACK _____	SEASONAL ALLERGIES _____
(type _____)	HEPATITIS/LIVER TROUBLE _____	STROKE _____
CANCER (type _____)	HIGH FEVER _____	SUDDEN CHANGES _____
CONVULSIONS/EPILEPSY _____	KIDNEY PROBLEMS _____	IN HEARING _____
DIABETES _____	MENINGITIS _____	THYROID DISEASE _____
EAR INFECTION _____		OTHER _____

### MEDICATIONS \_\_\_\_\_ None \_\_\_\_\_ List attached

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

Name	Dose (i.e. mg, ml)	Name	Dose (i.e. mg, ml)
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	____		
MACHINERY	YES	____	NO	____		

DO YOU WEAR HEARING PROTECTION? NO \_\_\_\_ OCCASIONALLY \_\_\_\_ ALL THE TIME \_\_\_\_

PAIN IN THE EAR                      RIGHT \_\_\_\_ LEFT \_\_\_\_ NONE \_\_\_\_

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.**

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

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

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

I have the right to revoke this consent. Such revocation must be submitted to the Privacy Officer in writing. The revocation shall be effective except in the extent that Tallahassee Ear, Nose & Throat has already acted in reliance within the guidelines of the consent. If the consent is not signed or is terminated after signature, Tallahassee Ear, Nose & Throat may refuse to treat me or continue to treat me (except as required by law to treat individuals) as consent is required for general practice operation.

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, emails, texts, voicemails, billing statements, or communication through the secure patient portal to the guarantor on my account. I acknowledge that email, voicemail, and cell phones are not secure forms of communication. 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.

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

I give permission for the contacts listed below to be given information regarding my medical conditions and diagnoses (including treatments, financial account, and healthcare options) with:

.....  
If no one, please check here: ☐

•Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_\_ Relationship: \_\_\_\_\_

•Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_\_ Relationship: \_\_\_\_\_

•Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_\_ Relationship: \_\_\_\_\_

•Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_\_ Relationship: \_\_\_\_\_

•Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer. A copy of this form can be provided upon request.

\_\_\_\_\_  
**Patient Signature or Guardian Signature Required**

INTERNAL USE ONLY: \_\_\_\_\_  
Employee Signature Date Names Entered