

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.

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. 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: _____

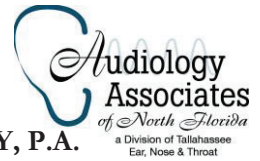
MEDICATION REPOSITORY:

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 _____ (type _____)	HEART ATTACK _____	SEASONAL ALLERGIES _____
CANCER (type _____)	HEPATITIS/LIVER TROUBLE _____	STROKE _____
CONVULSIONS/EPILEPSY _____	HIGH FEVER _____	SUDDEN CHANGES _____
DIABETES _____	KIDNEY PROBLEMS _____	IN HEARING _____
EAR INFECTION _____	MENINGITIS _____	THYROID DISEASE _____
		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

EAR RELATED SURGERIES AND DATES

Allergy	Reaction	Surgery	Date
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	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?

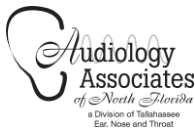
NOT READY 1 2 3 4 5 6 7 8 9 10 START NOW

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 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, 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 the contacts listed below to be given information regarding my medical treatment/care, financial account, and emergency information 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 for subsequent appointments in our office.

•Name: _____ DOB: ___/___/___ Phone: _____

Relationship: (please circle one)

Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other _____

•Name: _____ DOB: ___/___/___ Phone: _____

Relationship: (please circle one)

Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other _____

•Name: _____ DOB: ___/___/___ Phone: _____

Relationship: (please circle one)

Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other _____

•Name: _____ DOB: ___/___/___ 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 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