

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

TODAY'S DATE: _____

PATIENT INFORMATION:

Primary Care Physician: _____ Referring Physician: _____

Last Name: _____ First Name: _____ Middle Initial: ____ Age: _____

Social Security #: _____ Birthdate: ____ / ____ / ____ Birth Sex: M F X Gender: M F X

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Marital Status (circle one): Single Married Separated Divorced Widowed

Race (circle one): Other American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic / Non-Hispanic Language: _____

Day/Best #: (____) _____ Cell #: (____) _____

ALT #: (____) _____ Home #: (____) _____

Email: _____

CONFIRMATION

PREFERENCE:

☐ TEXT

☐ CALL

☐ EMAIL

*Chose
one
option*

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

PRIMARY INSURANCE CARRIER:

Insurance: _____

Policy Number: _____

Insurance Phone Number: _____

SECONDARY INSURANCE CARRIER:

Insurance: _____

Policy Number: _____

Insurance Phone Number: _____

PATIENT GUARANTOR/LEGAL GUARDIAN INFORMATION

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

**** If you are the appointed legal guardian- 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.**

Please complete if the patient is under the age of 18 or patient has a legal guardian:

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. A \$30 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. We are not responsible for providing estimates for services outside our office, such as cytology, pathology or labs.

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 printed and/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 Provider (APRN/PA) 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 data share/health information exchange.

I understand photographs, audio, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. Audio and transcripts are never stored or saved to ensure privacy and security.

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 and CT services offered on-site by Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: Spencer E. Gilleon, M.D., Adrian P. Roberts, M.D., Marie O. Becker, M.D., Joseph C. Soto, M.D., Graham T. Whitaker, M.D., and Kyle Kiliniski M.D. We feel the availability of both physicians and doctors of audiology in our group is advantageous to our patients, **but should you wish to have an alternative provider for these services, we will provide a list upon request.** In addition, some of these physicians have ownership in the Red Hills Surgical Center. **Upon your request, you may select any facility for surgical services where we are credentialed. I acknowledge this disclosure of ownership and my freedom to request any facility.**

SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT:

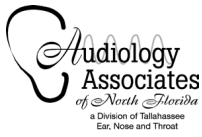
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in 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.

Consent to Use/Disclose Information for Treatment, Payment of Healthcare Operations, and Behavior Policy

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 printed, 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 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, text, 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. I understand photographs, audio, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. Audio and transcripts are never stored or saved to ensure privacy and security.

To provide the highest quality medical care, our practice requires that patients give their full attention during medical appointments. Accurate diagnosis and effective treatment depend on clear communication, careful listening, and focused interaction between the patient and physician. During your visit, patients are expected to refrain from using cell phones, tablets, smartwatches, laptops, or other electronic devices for activities such as texting, phone calls, internet browsing, social media, or gaming. These activities can distract both the patient and the provider, interfere with important medical discussions, and may impact the physician's ability to properly assess symptoms, identify underlying conditions, and recommend the most appropriate course of treatment.

If a phone/electronic device must be used for a medically relevant purpose such as reviewing medication lists, medical records, photos of symptoms, or participating in a medically necessary call please inform the provider or staff member in advance. Failure to comply with this policy may result in the appointment being paused, rescheduled, or ended to ensure that care is delivered safely and effectively.

We expect our patients to respect the privacy of other patients. If you obtain information about another patient, you are to notify us immediately so that we can take corrective action. **We expect our staff and physicians to treat you in a respectful manner. We ask that you conduct yourself in a manner that is respectful as well. If at any time your behavior is demeaning or disrespectful in the office, via the phone or social media we reserve the right to discharge you from the practice.**

Patients under the age of 18: parent or legal guardian must be listed on this form for all visits 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: _____

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 or Guardian Signature Required _____

Processed by: _____ Date: _____

H001-23- Aug 2026



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

www.TallyENT.com



Patient Name: _____ **DOB:** _____

Please be advised there are times when our providers need to perform an in-office procedure to correctly diagnose and treat problems. **Procedures performed in our office are not included in the standard visit but are in the best interest of patient care.** Procedures will be billed separately and will be in addition to a regular office visit charge.

Insurance carriers classify these procedures as “surgery” and apply the charges to your surgical deductible, copayment, and/or co-insurance amount.

We are providing this information to notify you in advance so you are not surprised when you receive your explanation of benefits from your insurance and it states a “surgical procedure” was performed.

There may be a difference in the estimated amount collected at check-out after your visit and the amount your insurance determines is patient responsibility.

Amounts collected at the time of service are simply an estimate. The final balance will not be known until after review by your insurance company.

Examples of procedures include, but are not limited to, the following:

Fiberoptic laryngoscopy (Scope of Throat): A long, thin, fiberoptic scope (either rigid or flexible) will be passed through the nasal cavity or into the throat. The fiberoptic scope enables the physician to visualize areas of the throat not readily seen using any other means.

Nasal endoscopy (Scope of Nose): A scope attached to a light source will be used to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum or visual inspection.

Tympanogram: This is an examination used to test the condition of the middle ear and mobility of the eardrum (tympanic membrane) and the conduction bones by creating variations of the air pressure in the ear canal.

Other procedures: Ear cleanings, hearing tests, CT scans and ultrasounds

When recommended, the above procedures are necessary to properly diagnose and treat your medical condition, and if not performed, may limit our ability to provide an appropriate treatment or surgical solution.

If you have additional questions, please feel free to speak to our staff and/or contact your insurance carrier for more information.

By signing below, I acknowledge that in-office procedures are separate from the office visit and understand that I am responsible for any balance that my insurance company applies to the deductible/copay/coinsurance according to my individual policy.

Patient/Guardian Signature: _____ Date: _____

SURGICAL, MEDICAL & SOCIAL HISTORY

Page 1

PATIENT'S NAME _____ DOB: _____

****PLEASE USE BLACK INK ONLY******PAST MEDICAL HISTORY: (FOR PATIENT ONLY)** Are you currently pregnant? ☐ YES ☐ NO

☐ NONE	☐ GERD	☐ Seizure disorder
☐ Allergies	☐ Headaches, migraines	☐ Sleep apnea
☐ Anemia	☐ Headaches	☐ Stroke
☐ Anxiety	☐ Hearing disorder	☐ Tinnitus
☐ Asthma	☐ High Blood Pressure	☐ Vertigo
☐ Birth trauma	☐ High Cholesterol	☐ HIV/AIDS
☐ Bleeding disorder	☐ Hyperthyroidism	Other: _____
☐ Cancer	☐ Hypothyroidism	Other: _____
☐ Cleft lip	☐ Malignant Hyperthermia	Other: _____
☐ Cleft palate	☐ Micrognathia	Other: _____
☐ Coronary artery disease	☐ Microtia	Other: _____
☐ Depression	☐ Multinodular goiter	Other: _____
☐ Diabetes	☐ Obesity	Other: _____
☐ Emphysema	☐ Otitis media	
☐ ENT Syndromes	☐ Otosclerosis	

SURGICAL HISTORY:☐ NONE

SURGERY	YEAR	YEAR
1. _____	_____	4. _____
2. _____	_____	5. _____
3. _____	_____	6. _____

FAMILY HISTORY: (For blood relative only; please list each family member below) ☐ NONE

☐ Allergies: _____	☐ Hearing disorder: _____
☐ Asthma: _____	☐ Hearing disorder: _____
☐ Autoimmune disease: _____	☐ Hypertension: _____
☐ Blood disorder: _____	☐ Malignant Hyperthermia: _____
☐ Cancer: _____	☐ Migraines: _____
☐ Cardiovascular disease: _____	☐ Obesity: _____
☐ Chronic otitis media: _____	☐ Kidney disease: _____
☐ Cleft lip/palate: _____	☐ Seizure disorder: _____
☐ Coronary artery disease: _____	☐ Sickle cell disease: _____
☐ Cleft palate: _____	☐ Sleep apnea: _____
☐ Deafness: : _____	☐ Stroke: _____
☐ Depression: _____	☐ Thyroid disorder: _____
☐ Developmental delay: _____	Other _____
☐ Diabetes: _____	Other _____
☐ GERD: _____	Other _____
☐ High cholesterol: _____	Other _____

SOCIAL HISTORY:**TOBACCO USAGE:** ☐ Current ☐ Former ☐ Never ☐ UnknownType: ☐ Chewing/Snuff/Smokeless ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ VapeUnits/day: _____ # Years Used: _____ Ever tried to Quit: ☐ Yes ☐ No Age quit: _____Passive smoke exposure: ☐ Yes ☐ No**ALCOHOL USE:** Drinks alcohol: ☐ Yes ☐ No ☐ Formerly If formerly, year quit: _____Type: ☐ Beer ☐ Liquor ☐ Wine Amount: _____Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially**RECREATIONAL DRUGS USAGE:** ☐ Current ☐ Former ☐ Never**STEROID DRUG USAGE:** ☐ Current ☐ Former ☐ Never

PATIENT'S NAME: _____ DOB: _____

OCCUPATION: _____PREFERRED PHARMACY: _____MEDICATIONS: _____ None _____ List attached

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

Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

ALLERGIES - Please list any MEDICATION allergies below: _____ No known MEDICATION allergies
 _____ Shellfish/Contrast Dye/Iodine allergy
 _____ Latex allergy

Name	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

REVIEW OF SYSTEMS: (Please check all that apply currently for the patient)

☐ Chills	☐ Visual changes	☐ Difficulty falling asleep
☐ Fatigue	☐ Hearing loss	☐ Difficulty staying asleep
☐ Fever	☐ Apnea during sleep	☐ Excessive daytime sleepiness
☐ Weight loss	☐ Shortness of breath	☐ Non-restorative sleep
☐ Weight gain	☐ Snoring	☐ Numbness in extremities
☐ Night sweats	☐ Wheezing	☐ Syncope
☐ Blurred vision	☐ Chest pain	☐ Tingling
☐ Choking on liquids	☐ Heart murmur	☐ Tremor
☐ Choking on solids	☐ Palpitations	☐ Weakness
☐ Double vision	☐ Abdominal pain	☐ Anxiety
☐ Dizziness	☐ Constipation	☐ Depression
☐ Drooling	☐ Diarrhea	☐ Hallucinations
☐ Difficulty swallowing	☐ Heartburn	
☐ Ear drainage	☐ Vomiting	OTHERS:
☐ Hoarseness	☐ Changes in urine color	_____
☐ Mouth ulcers	☐ Difficulty with urination	_____
☐ Ear pain	☐ Urinary frequency	_____
☐ Sore throat	☐ Cold intolerance	_____
☐ Ringing in ears	☐ Heat intolerance	_____
☐ Vertigo	☐ Increased thirst	

I have completed this medical 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 and treatment. I hereby consent to treatment.

PATIENT SIGNATURE_____
DATE