

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:

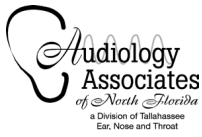
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in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

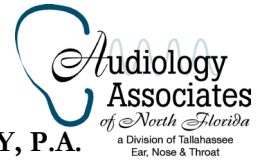
If you have additional questions, please feel free to speak to our staff and/or contact your insurance carrier for more information.

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: _____



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

NEW PATIENT 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:

ACOUSTIC NEUROMA _____	EAR INFECTION _____	PARKINSON'S DISEASE _____
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 _____
DEMENTIA _____	MENINGITIS _____	THYROID DISEASE _____
DIABETES _____	MENIERE'S 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

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

EAR RELATED SURGERIES

PLEASE MARK ALL RESPONSES THAT APPLY TO YOU:

MIDDLE EAR/EAR DRUM SURGERY (i.e. ear drum, mastoid, _____
stapes, ossicular chain, cholesteatoma) _____
PE TUBES _____
ACOUSTIC NEUROMA _____

SOCIAL HISTORY

SMOKE/VAPE: NEVER _____ CURRENTLY _____ PREVIOUSLY _____ NUMBER OF PACKS PER DAY? _____
DRINK ALCOHOL: NEVER _____ CURRENTLY _____ PREVIOUSLY _____ NUMBER OF DRINKS PER DAY? _____
RECREATIONAL DRUG USE: NEVER _____ CURRENTLY _____ PREVIOUSLY _____

STEROID 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 ____	
WOODWORKING	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/IMBALANCE 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 CHOOSE OUR CLINIC FOR YOUR HEARING CARE? FRIEND/FAMILY REFERRAL ____
ONLINE REVIEWS ____ DOCTOR REFERRAL ____ PRINT AD ____ RADIO ____ SEMINAR ____ TV AD ____
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