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. <u>If no insurance card is available</u>, please complete the following information:

Insurance Co: _____

Policy Number: _____

Insurance Co: _____

Policy Number: _____

PARENT/LEGAL GUARDIAN INFORMATION

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

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

****You must have <u>court ordered</u> 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: (<u>please circle one</u>) 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. 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: _____

PATIENT'S NAME_____ **DOB**: _____

****PLEASE USE BLACK INK ONLY****

HEALTH MAINTENANCE:

If applicable, please provide most recent date (approximate month/year) and if test was normal or abnormal:

	Results		Results
Mammogram: _____	_____	**Flexible Sigmoidoscopy:** _____	_____
Colonoscopy: _____	_____	**Pneumonia Vaccination:** _____	

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 ____ Unknown

Type: ____Chewing/Snuff/Smokeless _____ Cigar ____ Cigarettes ____ Pipe ____ Vape

Units/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**: _____

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

OTHERS:

_____
_____
_____
_____
_____

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**

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