Ear, Nose & Throat Associates of South Florida – Patient Information

Please Fill Out Form Completely

**Race and Ethnicity questions are required to be asked to the patient by the Federal Government

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: F___ M___ SSN _____ Marital Status: M___ S___ D___ W___ Other___

Please check appropriate response:

**Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____

Native Hawaiian/Pacific Islander_____ Other Race_____ White_____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name: _____

Patient's Address: _____

Street City, State Zip

Patient's 2nd Address: _____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone# _____

Whom may we thank for referring you? _____

Referring Physician: _____ Primary Care Physician: _____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____ Address: _____ Tele# _____

Insurance Information

Primary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____ Group# _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____ Group# _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Ear, Nose & Throat Associates of South Florida, PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles. co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. Yes_____ No_____

Signature: _____ Date: _____

Ear, Nose and Throat Associates
of South Florida, P.A.
Caring For Our Patients Since 1963
www.entsf.com

Personal Health Information

I hereby authorize the disclosure of **Personal Health Information** to the individual(s) listed below and via answering machine and/or email unless specifically excluded below.

To the following individuals: _____ Birthday:_____

_____Birthday:_____

_____Birthday:_____

Special Restrictions:_____

Cancellation Policy

I hereby acknowledge that I am responsible, and it is in my best medical interest to attend any scheduled appointments and/or follow-up appointments with Ear, Nose and Throat Associated of South Florida, P.A. as recommended by my Physician. I further understand that if my Physician orders/recommends out-patient diagnostic imaging testing, a sleep study, allergy or laboratory testing, or Audiology testing, it is because he/she feels that it is in my best interest. And finally, I understand that the Practice has a "no-show" policy in effect, which requires twenty-four (24) hours notice if I must cancel my appointment. If I fail to abide by this policy, I will be responsible to pay a charge of $50.00 per occurrence. A $100.00 charge will be assessed if I "no-show" for Allergy Testing, Diagnostic Audiology Testing and/or Flexible Endoscopic Swallowing Studies. A cancellation fee of $100.00 will be charged if surgery is cancelled within seven (7) days of the scheduled surgery date. In addition, we will impose a $25.00 service charge if you are unable to pay your co-pay or co-insurance at the time of service. There is a charge for the completion of forms, $10.00 for 1 page and $25.00 for 2 or more pages.

This Consent Is Valid From The Date Executed Until Revoked In Writing By The Patient.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient Name: _____

EAR, NOSE & THROAT ASSOCIATES OF SOUTH FLORIDA
MEDICAL INFORMATION SHEET

NAME_____ DATE_____

FAMILY DOCTOR/REFERRED BY_____

PATIENT MEDICAL HISTORY

REASON FOR VISIT_____

HOW LONG_____ HOW SEVERE_____

PREVIOUS TREATMENT FOR THIS PROBLEM OR HAVE YOU HAD ANY DIAGNOSTIC TESTING PERFORMED?_____

IF FEMALE, ARE YOU PREGNANT? ☐YES ☐NO ARE YOU ALLERGIC TO LATEX? ☐YES ☐NO

DO YOU TAKE ANY HERBAL OR HOMEOPATHIC REMEDIES? ☐YES ☐NO IF SO, WHAT:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

PHARMACY NAME: _____ **LOCATION:** _____

EAR/NOSE/THROAT (PLEASE CHECK ALL THAT APPLY)

EAR	☐PAIN ☐WAX IMPACTION	☐VERTIGO ☐DRAINAGE	☐RINGING ☐HEARING LOSS	☐HISTORY OF INFECTION ☐NOISE EXPOSURE
NOSE	☐BLEEDING ☐CONGESTION	☐OBSTRUCTION ☐STUFFINESS	☐PREVIOUS INJURY ☐POST NASAL DRAINAGE	
THROAT	☐SORE THROAT	☐COUGH	☐HOARSENESS	☐DIFFICULTY SWALLOWING
ALLERGY/ SINUS	☐HEADACHES ☐INFECTIONS	☐FACIAL PRESSURE ☐ITCHY/WATERY EYES	☐ASTHMA	☐SNEEZING

SYSTEM REVIEW (PLEASE CHECK ALL THAT APPLY)

SLEEP PATTERNS	☐SNORING	☐DAYTIME FATIGUE	☐AIRWAY OBSTRUCTION
CONSTITIUTIONAL	☐FEVER	☐WEIGHT LOSS	☐WEIGHT GAIN
SKIN	☐LESIONS	☐SKIN CANCER	☐RASHES/ ITCHES
EYES	☐GLAUCOMA	**Squamous cell, Basal cell** ☐VISUAL CHANGES	☐DOUBLE VISION
CARDIOVASCULAR	☐HEART ATTACK ☐IRREGULAR HEART BEAT	☐HEART DISEASE	☐CHEST PAINS ☐HIGH BLOOD PRESSURE
RESPIRATORY	☐PNEUMONIA	☐EMPHYSEMA	☐BRONCHITIS
GASTROINTENSTINAL	☐ULCERS/ COLITIS	☐ NAUSEA	☐HIATAL HERNIA/REFLUX
G/U	☐KIDNEY STONES	☐RECURRENT UTI	☐BLOOD IN URINE
MUSCULOSKELETAL	☐NECK INJURY	☐RHEUMATOID ARTHRITIS	
NEUROLOGICAL	☐DIZZINESS	☐STROKE ☐MIGRAINES	☐WEAKNESS/NUMBNESS
ENDOCRINE	☐THYROID	☐SWEATING	☐DIABETES
ALLERGIC/IMMUNOLOGIC	☐SKIN RASHES	☐INFECTIONS	☐ALLERGY INJECTIONS

PLEASE TURN OVER AND COMPLETE OTHER SIDE

PRESENT MEDICATIONS (PLEASE LIST DOSAGE AND FREQUENCY)

_____ _____ TIME/S PER DAY
_____ _____ TIME/S PER DAY
_____ _____ TIME/S PER DAY
_____ _____ TIME/S PER DAY
_____ _____ TIME/S PER DAY
_____ _____ TIME/S PER DAY

PAST HISTORY (PLEASE CHECK ALL THAT APPLY)

CHILDHOOD ILLNESSES ☐MEASLES ☐MUMPS ☐CHICKEN POX

IMMUNIZATIONS ☐TETANUS ☐MMR ☐DPT

MAJOR ILLNESSES/INJURIES (PLEASE LIST)
_____ APPROXIMATE DATE _____
_____ APPROXIMATE DATE _____
_____ APPROXIMATE DATE _____

SURGERIES/OPERATIONS (PLEASE LIST)
_____ APPROXIMATE DATE _____
_____ APPROXIMATE DATE _____
_____ APPROXIMATE DATE _____

HEIGHT: _____ WEIGHT: _____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ALLERGIES ☐THYROID ☐HEARING LOSS
☐ASTHMA ☐DIABETES ☐HEAD/NECK CANCER
☐BLEEDING DISORDERS ☐ANESTHESIA PROBLEMS

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

TOBACCO ☐NONE ☐CHEWING ☐QUIT ____ YEARS AGO ____PACKS/DAY FOR ____ YEARS
Are you or your child (ren) exposed to environmental/second-hand smoke ☐NO ☐YES
Exposure to tobacco smoke in perinatal period? (during pregnancy or within the first twenty eight (28) days of life) ☐NO ☐YES
Any Occupational Exposure to environmental tobacco smoke? ☐NO ☐YES
Tobacco dependence? ☐NO ☐YES

CAFFEINE ☐NONE ☐YES circle amount 1-3 cups/beverages 4-6 cups/beverages 7 or more cups/beverages

ALCOHOL ☐NONE ☐RARE ☐SOCIAL AMOUNT _____

DRUG USE ☐NONE ☐YES _____

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Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to Ear, Nose & Throat Associates of South Florida on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles and co-pays, and that payments are due at the time of services are rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay the collection agency's fees for collection, any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Patient Signature _____ **Date** _____

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Patient Signature _____ **Date** _____

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT Associates of South Florida, PA., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, CT's, allergy testing and treatment, and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Patient Signature _____ **Date** _____

Print Patient Name _____ **Patient D.O.B** _____

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Payment Policy

Please carefully read and sign this form as it concerns you, the patient.

- **You are Responsible for your Insurance Policy**

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient or the financially responsible party, being responsible for all cost incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out whether or not we are providers for your specific network.**

- **Referrals**

If you need a referral from your insurance company or from your Primary Care Physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you may be required to reschedule your appointment should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us.

- **Non-Participating Provider Policy**

If we are not a provider for your insurance company, we will collect our fees in full at the time of Service.

- **Your Financial Responsibility**

You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at the time of service. Because we are specialists, some diagnostic/invasive procedures, may not be considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage to avoid confusion and out of pocket expense.

Patient Signature _____ **Date** _____

Print Patient Name _____ **D.O.B**_____

Revised 12.28.15

Ear, Nose and Throat Associates of South Florida, P.A.

Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ No Known Drug Allergies

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please check response: ☐ **Yes** ☐ **No**

Patient/Guardian Signature: _____

Print Patient Name: _____ **D.O.B:**_____

Revised 12.28.15

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Medicare Consent

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient Signature _____ **Date** _____

Print Patient Name _____ **Patient D.O.B** _____