

DRS. BERGHASH & LANZA, P.L., D/B/A SOUTH COAST EAR, NOSE & THROAT

DATE: _____

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

PERMANENT MAILING ADDRESS _____

APARTMENT/LOT NUMBER _____

CITY _____ STATE _____ ZIP CODE _____ SEX _____

HOME PHONE _____ WORK PHONE _____ EXT _____ MOBILE PHONE _____

DATE OF BIRTH _____ AGE _____ SS # _____ MARITAL STATUS _____

EMPLOYER _____ POSITION _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS: _____

Please select one: RACE: 1 Asian, 2 Black, 3 Caucasian, 4 Hispanic, 5 American Indian/Alaskan National, 6 Multi-Racial

REFERRING PHYSICIAN _____

ADDITIONAL INFORMATION

SEASONAL ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

IF MINOR, PARENT/GUARDIAN INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT _____

STREET ADDRESS _____

APARTMENT/LOT NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____ POSITION _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ EXTENSION _____

DATE OF BIRTH _____ SS# _____

SPOUSE'S INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

EMPLOYER _____ POSITION _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ EXTENSION _____

DATE OF BIRTH _____ SS# _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

EMERGENCY CONTACT

NAME OF NEAREST RELATIVE _____
HOME PHONE _____ WORK PHONE _____ EXTENSION _____

POLICYHOLDER INFORMATION (THE PERSON WHO PAYS THE INSURANCE PREMIUM)

(I.E. WHO'S PAYCHECK IS DEDUCTED - SELF, HUSBAND, WIFE, EX-HUSBAND, EX-WIFE, IF CHILD, MOTHER, FATHER, STEP PARENT)

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
EMPLOYER _____
DATE OF BIRTH _____ SS# _____
HOME PHONE _____ WORK PHONE _____ EXTENSION _____

INSURANCE COMPANY INFORMATION

PLEASE PRESENT YOUR INSURANCE CARDS TO PHOTOCOPY AND TELL US THE FOLLOWING:

NAME OF **PRIMARY** INSURANCE _____

NAME OF **SECONDARY** INSURANCE _____

IF WE PARTICIPATE WITH YOUR INSURANCE PLAN, WE WILL ASK YOU TO PAY ANY CO-PAYMENT, DEDUCTIBLE OR CO-INSURANCE AMOUNTS AT THE TIME OF SERVICE AND SUBMIT A CLAIM TO YOUR INSURANCE COMPANY.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN, WE WILL ASK YOU TO PAY IN FULL AT THE TIME OF SERVICE AND AS A COURTESY SUBMIT A CLAIM TO YOUR INSURANCE COMPANY.

IF YOU DO NOT PRESENT ANY INSURANCE CARDS WE WILL PRESUME YOU DO NOT HAVE ANY INSURANCE COVERAGE AND PAYMENT IN FULL WILL BE DUE AT THE TIME OF SERVICE.

**DRS. BERGHASH & LANZA, P.L., d/b/a SOUTH COAST EAR, NOSE & THROAT
MEDICAL INFORMATION SHEET**

NAME _____ DATE _____

FAMILY DOCTOR/REFERRED BY _____

PATIENT MEDICAL HISTORY

REASON FOR VISIT _____

HOW LONG _____ HOW SEVERE _____

PREVIOUS TREATMENT FOR THIS PROBLEM _____

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

SYSTEM REVIEW (PLEASE CHECK ALL THAT APPLY)

- | | | | |
|-----------------------------|---|---|---|
| SLEEP PATTERNS | <input type="checkbox"/> SNORING | <input type="checkbox"/> DAYTIME FATIGUE | <input type="checkbox"/> AIRWAY OBSTRUCTION |
| CONSTITUTIONAL | <input type="checkbox"/> FEVER | <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> WEIGHT GAIN |
| SKIN | <input type="checkbox"/> LESIONS | <input type="checkbox"/> SKIN CANCER | <input type="checkbox"/> RASHES/ ITCHES |
| EYES | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> VISUAL CHANGES | <input type="checkbox"/> DOUBLE VISION |
| CARDIOVASCULAR | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CHEST PAINS |
| | <input type="checkbox"/> IRREGULAR HEART BEAT | | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| RESPIRATORY | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> BRONCHITIS |
| GASTROINTESTINAL | <input type="checkbox"/> ULCERS/ COLITIS | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> HIATAL HERNIA/REFLUX |
| G/U | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> RECURRENT UTI | <input type="checkbox"/> BLOOD IN URINE |
| MUSCULOSKELETAL | <input type="checkbox"/> NECK INJURY | <input type="checkbox"/> RHEUMATOID ARTHRITIS | |
| NEUROLOGICAL | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> WEAKNESS/NUMBNESS |
| ENDOCRINE | <input type="checkbox"/> THYROID | <input type="checkbox"/> SWEATING | <input type="checkbox"/> DIABETES |
| ALLERGIC/IMMUNOLOGIC | <input type="checkbox"/> SKIN RASHES | <input type="checkbox"/> INFECTIONS | <input type="checkbox"/> 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	<input type="checkbox"/> MEASLES	<input type="checkbox"/> MUMPS	<input type="checkbox"/> CHICKEN POX
IMMUNIZATIONS	<input type="checkbox"/> TETANUS	<input type="checkbox"/> MMR	<input type="checkbox"/> DPT
MAJOR ILLNESSES/INJURIES (PLEASE LIST)	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
SURGERIES/OPERATIONS (PLEASE LIST)	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> THYROID	<input type="checkbox"/> HEARING LOSS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEAD/NECK CANCER
<input type="checkbox"/> BLEEDING DISORDERS		<input type="checkbox"/> ANESTHESIA PROBLEMS

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

TOBACCO NONE CHEWING QUIT _____ YEARS AGO _____ PACKS/DAY FOR _____ YEARS

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 _____

PHYSICIAN USE ONLY: REVIEWED WITH PATIENT

_____	_____	_____	_____
Initials/Date	Initials/Date	Initials/Date	Initials/Date

DRS. BERGHASH & LANZA, P.L., D/B/A SOUTH COAST EAR, NOSE & THROAT

PATIENT NAME: _____

I hereby give consent for any necessary medical treatment for the above named patient or for whom I am legally responsible. This consent for treatment includes medical care provided today and those of subsequent appointments.

Privacy Notice

In accordance with the Health Insurance Portability and Accountability act of 1996, patients of this Practice are entitled to the greatest degree of privacy possible. The release of medical information to any insurance carrier, other entities directly associated with the offices of Drs. Berghash & Lanza, P.L., d/b/a South Coast Ear, Nose & Throat, primary care provider and/or referral physician in connection with treatment is authorized. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. No other disclosures will be made without written authorization from the patient or guardian. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours and to make comments to the same. All requests must be made in writing.

Assignment of Benefits

I hereby assign all insurance benefits and direct payment to Dr. Leslie R. Berghash, Dr. John T. Lanza, Dr. Camysha H. Wright, Dr. Jacob W. Zeiders, Joan M. Gautreau, A.R.N.P. and/or Jeffrey M. McFarlane, A.R.N.P. I also understand that I am responsible for final payment of medical services regardless of my insurance coverage.

Financial Responsibility

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am responsible for co-insurance amounts, deductibles and/or payment in full at the time of each visit. Providing the highest quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. Unfortunately, if you do not inform us of special requirements necessary by your plan, and we order services such as laboratory, supplies, x-ray, etc. that are not covered by your plan, payment for these services will be your responsibility.

Medicare patients are responsible for meeting an annual deductible of \$155.00. Once your deductible has been satisfied, Medicare will pay at a rate of 80% of the submitted claim and patients will be responsible for paying their 20% at the time of the visit. As a courtesy, we will file secondary insurances.

Authorization for Treatment/Release of Information

In connection with the medical services that I am receiving from the above named physician or physician group, I hereby authorize the above-named physician and/ or group/associates to disclose any/all information concerning my medical condition and treatment (including, but not limited to, super confidential information concerning sexually transmitted disease, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to:

- A. Any third party payer covering the medical services of the patient;
- B. Other health care professionals and institutions involved in the delivery of health care;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- E. Pharmacies; and
- F. As otherwise required by law.

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Marketing & Announcements - Pursuant to C.F.R. 164.532, I authorize Drs. Berghash & Lanza, P.L., d/b/a South Coast Ear, Nose & Throat to use my protected health information to send me marketing and/or promotional materials via mail, email or text.

Consent for Photographs - I consent that photographs may be taken of me or parts of my body, under the following conditions: 1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him. 2. The photographs shall be used for medical records and, if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name reasonable steps shall be taken to preserve my identity.

In each case, the Practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I have read and understand the above. I further understand that I have been given access to the physician's privacy notice and that a copy of which was available for my taking in the Patient's Bill of Rights Notebook. I have had the opportunity to place special restrictions upon the consent hereby given. I further understand that special requests for restrictions must be submitted to the Practice in writing and must be reviewed and approved by the designated Privacy Officer:

I also 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: _____

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 Drs. Berghash & Lanza, P.L., d/b/a South Coast Ear, Nose & Throat 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 affect, 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 cancellation fee of \$100.00 will be charged if you cancel your surgery within seven (7) days of the scheduled surgery date.

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

Patient Signature

Date

Witness Signature

Date



SCENT
SOUTH - COAST - EAR - NOSE - THROAT

www.otodocs.com

DRS. BERGHASH & LANZA, P.L. D/B/A
South Coast Ear, Nose & Throat

LESLIE R. BERGHASH, M.D., F.A.C.S.*

JOHN T. LANZA, M.D., F.A.C.S.*

CAMYSHA H. WRIGHT, M.D.

JACOB W. ZEIDERS III, M.D.*

*BOARD CERTIFIED

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Cash, Checks, Debit Cards, Visa, MasterCard, Discover and American Express.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor, in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the Practice within a reasonable period of time, we will have to look to you for payment. If we later receive a check from your insurance company, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them on your behalf and you are required to pay a copayment at the time of your visit.
4. If you are insured by a plan that we do not have prior arrangements with, we will prepare and send the claim for you, on an assigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. If you are seen in the hospital, we will bill your insurance company only for services that we provide. You are responsible for any balance due.
7. We have a \$50.00 “No-Show” policy which requires twenty four (24) hours notice if you cancel your appointment.

I have read and understand the Practice’s Financial Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice from time to time.

Signature of patient (or responsible party, if minor)

Date

Please print the name of the patient

DRS. BERGHASH & LANZA, P.L., d/b/a SOUTH COAST EAR, NOSE & THROAT
DIRECTIONS TO FORT PIERCE OFFICE
2100 Nebraska Avenue, Suite #203
Fort Pierce, Florida 34950
(772) 464-6055 telephone (772) 464-2446 facsimile

From US1 – North	Turn right on Virginia Avenue and go west. Follow to 25 th Street and turn right heading north. (Pass main entrance to Lawnwood Regional Medical Center) Look for Glenn Jones Chiropractic Office (corner of 25 th Street and Nebraska) and turn right onto Nebraska Avenue heading east. Go through a four-way stop and we are located in the two-story office building on the left (Directly across from the Lawnwood Regional Medical Center Emergency Department.) Our office is on the 2 nd Floor.
From US1 - South	Turn left on Virginia Avenue and go west. Follow to 25 th Street and turn right heading north. (Pass main entrance to Lawnwood Regional Medical Center) Look for Glenn Jones Chiropractic Office (corner of 25 th Street and Nebraska) and turn right onto Nebraska Avenue heading east. Go through a four-way stop and we are located in the two-story office building on the left (Directly across from the Lawnwood Regional Medical Center Emergency Department.) Our office is on the 2 nd Floor.
From I-95 - North	As you exit the interstate, approach the traffic signal and turn left. This will be Okeechobee Road. You will be heading east. The road forks past Wal-Mart, you want to take the right fork. Follow to 25 th Street and turn left and go north. (Pass the main entrance to Lawnwood Regional Medical Center) Look for Glenn Jones Chiropractic Office (corner of 25 th Street and Nebraska) and turn right onto Nebraska Avenue heading east. Go through a four-way stop and we are located in the two-story office building on the left (Directly across from the Lawnwood Regional Medical Center Emergency Department.) Our office is on the 2 nd Floor.
From I-95 - South	As you exit the interstate, veer to the right. This will be Okeechobee Road. You will be heading east. The road forks past Wal-Mart, you want to take the right fork. Follow to 25 th Street and turn left and go north. (Pass the main entrance to Lawnwood Regional Medical Center) Look for Glenn Jones Chiropractic Office (corner of 25 th Street and Nebraska) and turn right onto Nebraska Avenue heading east. Go through a four-way stop and we are located in the two-story office building on the left (Directly across from the Lawnwood Regional Medical Center Emergency Department.) Our office is on the 2 nd Floor.
From Florida Turnpike Fort Pierce	Upon exiting the tollbooth you will turn right at the traffic signal, which is Okeechobee Road. You will be heading east. You will cross under I-95 and pass Home Depot. The road forks past Wal-Mart, you want to take the right fork. Follow to 25 th Street and turn left and go north. (Pass the main entrance to Lawnwood Regional Medical Center) Look for Glenn Jones Chiropractic Office (corner of 25 th Street and Nebraska) and turn right onto Nebraska Avenue heading east. Go through a four-way stop and we are located in the two-story office building on the left (Directly across from the Lawnwood Regional Medical Center Emergency Department.) Our office is on the 2 nd Floor.

DRS. BERGHASH & LANZA, P.L., d/b/a SOUTH COAST EAR, NOSE & THROAT
DIRECTIONS TO PORT ST. LUCIE OFFICE
1801 SE Hillmoor Drive
Suite #B-105
Port St. Lucie, Florida 34952
(772) 398-9911 telephone (772) 398-4577 facsimile

From US1 – North	Turn left on Tiffany Avenue and remain in the right turn lane. Follow to the first traffic signal, which is Hillmoor Drive and turn right. On your left, you will pass the Hospital, a one story professional building and a nursing home and then you will see the Hillmoor Professional Plaza on your left. Pass the first two (2) entrances and utilize the third entrance. (Beside the pond and across from the apartment complex) You will notice the B on the staircase. Once you reach the top of the staircase, our office is the first office on your left. If you require use of an elevator, you should use the second entrance to the building (Main Entrance).
From US1 – South	Turn right on Tiffany Avenue and follow to the first traffic signal, which is Hillmoor Drive and turn right. On your left, you will pass the Hospital, a one story professional building and a nursing home and then you will see the Hillmoor Professional Plaza on your left. Pass the first two (2) entrances and utilize the third entrance. (Beside the pond and across from the apartment complex) You will notice the B on the staircase. Once you reach the top of the staircase, our office is the first office on your left. If you require use of an elevator, you should use the second entrance to the building (Main Entrance).
From I-95 – North or South St. Lucie West Boulevard	As you exit the interstate from North I-95, approach the traffic head east. If you are coming from South I-95, you must follow the bend toward the right. This will be St. Lucie West Boulevard and you will be heading east. Follow all the way to US1 and turn right. Follow US1 until you reach Tiffany Avenue where you will turn left. Follow to the first traffic signal, which is Hillmoor Drive and turn right. On your left, you will pass the Hospital, a one story professional building and a nursing home and then you will see the Hillmoor Professional Plaza on your left. Pass the first two (2) entrances and utilize the third entrance. (Beside the pond and across from the apartment complex) You will notice the B on the staircase. Once you reach the top of the staircase, our office is the first office on your left. If you require use of an elevator, you should use the second entrance to the building (Main Entrance).
From Florida Turnpike	As you exit the toll plaza you will make a large loop and end up facing the toll plaza at the intersection of Port St. Lucie Boulevard and Bayshore Boulevard. You should turn right and head east. You will remain on Port St. Lucie Boulevard until you reach US1. At US1, turn left and follow to Tiffany Avenue where you should turn right. Follow one block to Hillmoor Drive and turn right. On your left, you will pass the Hospital, a one story professional building and a nursing home and then you will see the Hillmoor Professional Plaza on your left. Pass the first two (2) entrances and utilize the third entrance. (Beside the pond and across from the apartment complex) You will notice the B on the staircase. Once you reach the top of the staircase, our office is the first office on your left. If you require use of an elevator, you should use the second entrance to the building (Main Entrance).

DIRECTIONS TO PORT ST. LUCIE OFFICE

(continued)

From Okeechobee	<p>Follow State Road #70 east until just west of Fort Pierce. At the cut-off by the new St. Lucie County Fair Grounds, veer right onto Midway Road and continue east Follow Midway Road to I-95. Merge onto I-95 south (right before the overpass) and exit at the next exit, which is St. Lucie West Boulevard. As you exit the interstate, approach the traffic signal and turn left. Follow all the way to US1 and turn right. Follow US1 until you reach Tiffany Avenue where you will turn left. Follow to the first traffic signal, which is Hillmoor Drive and turn right. On your left, you will pass the Hospital, a one story professional building and a nursing home and then you will see the Hillmoor Professional Plaza on your left. Pass the first two (2) entrances and utilize the third entrance. (Beside the pond and across from the apartment complex) You will notice the B on the staircase. Once you reach the top of the staircase, our office is the first office on your left. If you require use of an elevator, you should use the second entrance to the building (Main Entrance).</p>
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DRS. BERGHASH & LANZA, P.L., d/b/a SOUTH COAST EAR, NOSE & THROAT
DIRECTIONS TO OKEECHOBEE OFFICE
1916 Highway #441 North
Okeechobee, Florida 34972
(863) 357-7791 telephone (863) 357-6934 facsimile

From Fort Pierce State Road #70	Follow State Road #70 west. At the intersection of Highway #441 (aka Parrot Avenue), turn right. You will cross over railroad tracks. Look for the blue H sign for Raulerson Hospital. Our office is the building with a tin roof facing Highway #441, immediately past the hospital. Turn right on NE 19 th Drive and make your first left to Suite #1916. The Rodeo is directly across the street.
From Stuart	State Road #714 west. Follow to SW Martin Highway and turn right. (approx. 23 miles). Continue until you reach State Road #710 and turn right. When you reach State Road #70 turn left, you will now be heading west. At the intersection of Highway #441 (aka Parrot Avenue), turn right. You will cross over railroad tracks. Look for the blue H sign for Raulerson Hospital. Our office is the building with a tin roof facing Highway #441, immediately past the hospital. Turn right on NE 19 th Drive and make your first left to Suite #1916. The Rodeo is directly across the street.
From Moore Haven	East on State Road #70 until the intersection of Highway #441 (aka Parrot Avenue), turn left. You will cross over railroad tracks. Look for the blue H sign for Raulerson Hospital. Our office is the building with a tin roof facing Highway #441, immediately past the hospital. Turn right on NE 19 th Drive and make your first left to Suite #1916. The Rodeo is directly across the street.
From Highway #441- North	South on Highway #441. Pass the High School on your left. Turn left onto NE 19 th Drive and make your first left to Suite #1916. The Rodeo is directly across the street.
From Highway #441 - South	Go north on Highway #441. You will cross over railroad tracks. Look for the blue H sign for Raulerson Hospital. Our office is the building with a tin roof facing Highway #441, immediately past the hospital. Turn right on NE 19 th Drive and make your first left to Suite #1916. The Rodeo is directly across the street.