ENT ASSOCIATES OF SOUTH ATLANTA

Otolarynology, Head & Neck Surgery

Specializing in Surgical Treatment of Epilepsy, Depression, Sleep Apnea, Sinositis and other Ear, Nose and Throat Disorders in Children and Adults.

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CONSENT FOR DISCLOSURE

In general, The HIPAA privacy rule gives individuals the right to question a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

☐ HOME TELEPHONE ____________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Mobile Phone ________________________

☐ Work Phone ________________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call–back number only

☐ Written Communication

- ☐ OK to mail my home office address
- ☐ OK to mail my work/office address
- ☐ OK TO EMAIL

____

☐ OTHER SPOUSE/RELATIVE/OTHER

(Name)________________________________

(Name)________________________________

________________________________ ____________________

Patient Signature Date

____

Print Name Birth Date

ENT ASSOCIATES OF ATLANTA
PATIENT INFORMATION

DATE:________________________ REFERING DR_______________________
LAST NAME:____________________________FIRST:________________________MI:______
SSN:________________________________ DOB:___________________________

EMAIL ADDRESS:____
HOME ADDRESS:____
CITY:____________________________STATE:______________ZIP:____________
HOME PHONE:________________ CELL PHONE:________________WORK PHONE:_________________
EMPLOYER:____

SPOUSE OR PARENT INFORMATION

LAST NAME:______________________FIRST:__________________MI_______
SSN:_____________________________DOB:___________________________
ADDRESS:____
CITY:_______________________STATE:_______________ZIP:_____________
HOME PHONE:____________________WORK PHONE:____________________
EMPLOYER:____

INSURANCE INFORMATION

PRIMARY INSURANCE:____

POLICY#:_________________________________GRP#:____________________

POLICY HOLDERS NAME:____
SUBSCRIBER (CIRCLE ONE) SELF SPOUSE OTHER (ex:child)

SECONDARY INSURANCE:____

POLICY#:________________________________GRP#:____________________

POLICY HOLDERS NAME:____
SUBSCRIBER (CIRCLE ONE) SELF SPOUSE OTHER (ex:child)

PATIENT'S NAME____Birth Date:_________________________
What medical problem(s) brings you to this office?____

____

How did you learn about our practice?____

____

Who are your doctors?____

____

Do you have any *active* medical problems being treated by a Doctor?______________________________

____

Do you have any *other* medical problems?____

____

What PRESCRIPTION medicines do you take and why?

MEDICATION	BEING TAKEN FOR	MEDICATION	BEING TAKEN FOR

What other non – prescription (over the counter, herbal or homeopathic) medications do you take?____

____

____

Pharmacy name: _______________________________________ Phone#____________________________

Please list any hospitalizations or surgeries (Please give date and reason).

HOSPITALIZATION	REASON AND DATE

Do you have any allergies to medications? Please list the names and types of reaction.

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

Do you have any environmental allergies? ( ) Yes ( )No. To what?________________________
_____________________________________Have you ever been evaluated with allergy tests? ( ) Yes ( ) No

SOCIAL HISTORY:
Occupation: ____
Do you smoke? ( ) NO ( ) YES How much? _______________packs per day.
Do you drink: Caffeinated beverages? ( ) NO ( ) YES Alcohol? ( ) NO ( ) YES How much?______________
Do you live: ( ) Alone? ( ) With Spouse? ( ) with children? ( ) With friends? ( ) Assisted facility

CONTINUE ON OTHER SIDE

FOR CHILDREN:

Was the mother's pregnancy normal? ( ) Y ( ) N Birth Weight?

Did the child reach his / her milestones (seating, walking, talking, etc.,) on time?____

FAMILY HISTORY: Do any of your blood relations have problems with the following? Check any that apply:
( ) Asthma ( ) Diabetes ( ) Tuberculosis ( ) High Blood Pressure ( ) Stroke ( ) Headaches ( ) Hearing loss…
( ) Heart disease ( ) Allergies ( ) Cancer ( ) Thyroid disease ( ) Bleeding problems ( ) Problems with Anasthesia
( ) Autoimmune disease

PAST MEDICAL HISTORY:
Have you ever been diagnosed with cancer? ( ) NO ( ) YES Please give details:______________________________

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE CHECK ( ) THOSE THAT APPLY
GENERAL NO ( ) Fever ( ) Weight Change ( ) Fatigue
EYES NO ( ) Visual loss ( ) Glaucoma ( ) Cataracts ( ) Itchy Eyes ( ) Tearing ( ) Blurred vision
EARS NO ( ) Vertigo ( ) Dizziness ( ) Ringing Noises ( ) Hearing Loss ( ) Hearing Aid ( ) Infections ( ) Trauma ( ) Noise Exposure ( ) Ear ache ( ) Drainage
NOSE NO ( ) Discharge ( ) Clear ( ) colured ( ) thick ( ) thin ( ) post nasal drip ( ) obstruction ( ) Bleeding ( ) Sneezing
MOUTH NO ( ) Lumps ( ) Dental problems ( ) Tonsilitis ( ) Mouth sores
THROAT NO ( ) Hoarseness ( ) Voice Change ( ) Problem Swallowing ( ) Pain
NECK NO ( ) Pain ( ) Lumps ( ) Thyroid Nodules ( ) Swollen glands
SKIN NO ( ) Breast Lumps ( ) Psoriasis ( ) Skin Growths ( ) Rash ( ) Itching
LUNGS NO ( ) Wheezing ( ) Asthma ( ) COPD ( ) Bronchitis ( ) Emphysema ( ) Coughing up blood ( ) Chronic Cough ( ) Pneumonia ( ) Positive TB Test ( ) Shortness of breath
SLEEPING NO ( ) Snoring ( ) Apneaa ( ) Insomnia ( ) Waking up tired ( ) Daytime Tiredness
HEART NO ( ) High Blood Pressure ( ) Coronary heart disease ( ) Myocardial infarction ( ) Chest Pain( ) Mitral Valve Collapse ( ) Congestive Heart Failure ( ) Heart Valve Disease ( ) Angina ( ) Murmurs ( ) Rheumatic Fever
GASTRO-INTESTINAL NO ( ) Hiatal Hernia ( ) Heartburn ( ) Reflux ( ) Rectal Bleeding ( ) Ulcers ( ) Hepatitis Type ( ) Jaundice ( )Nausea ( ) Vomitting ( ) Colitis
GENITO-URINARY NO ( ) frequent urination ( ) Pain ( ) Discharge ( ) Incontinence ( ) Bloody Urine
MEN: ( ) Prostrate problem ( ) Hernias
WOMEN: ( ) Abnormal periods ( ) menopause ( ) Are you Pregnant? ( ) Y ( ) N
MUSCLE / JOINTS NO ( ) Muscle Pain ( ) back Pain ( ) Joint Pain ( ) Arthritis ( ) Lupus ( ) Gout
NEUROLOGICAL NO ( ) Headaches ( ) Migraines ( ) Imbalance ( ) Alzheimer's Disease ( ) loss of Consciousness ( ) Parkinson's Disease ( ) Head Trauma ( ) Tremors ( ) Fainting ( ) Seizures ( ) TIA's ( ) Stroke
PSYCHIATRIC NO ( ) Nervousness ( ) Anxiety ( ) Depression ( ) Mood Swings
ENDOCRINE NO ( ) Thyroid Disease ( ) Diabetes ( ) Glandular / Hormonal Problems
HEMATOLOGIC NO ( ) Slow to heal after cuts ( ) Easy Bruising or bleeding ( ) Immunocompromised status ( ) Transfusions ( ) Phlebitis ( ) Anemia

If this form is filled out by anyone other than the patient, please write the name and relationship.

NAME: ______________________________________RELATIONSHIP TO PATIENT_____________

I certify that this information is true and correct to the best of my knowledge. I will notify you if any changes occur

SIGNATURE:__________________________________DATE______________________________

I have reviewed the above information with the patient: MD SIGNATURE:_______________________

Name:__________________________________ Age:_______________________________

Today's Date:____________________________________Male/Female:__________________

How likely are you to doze or fall asleep in the following situations. In contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation :

0 = would never doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	_____________________________
Watching TV	______________________________
Sitting inactive in a public place (e.g. a movie theatre/ meeting)	_____________________________
As a passenger in a car for an hour without a break	______________________________
Lying down to rest in the afternoon when circumstances permit	_____________________________
Sitting and talking to someone	______________________________
Sitting quietly after lunch without alcohol	______________________________
In a car while stopped for a few minutes in traffic	______________________________

<u>E.N.T Associates of South Atlanta</u>

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PAYMENT POLICY
Physician / Patient's Agreement

Insurance:
Our office will file your insurance claim to your insurance company as a courtesy. Co-payments are due at sign-in for each office visit and payable by cash or check. Co-insurance (patient's responsible percentage) is due at check out-in for each visit. You are responsible for any service that your insurance company deems as not medically necessary (non-covered), which is due and payable (if known) before services are rendered. If it is discovered that your coverage is not valid the balance due is your responsibility for your account with our office. It is not the responsibility of your insurance company.
Please NOTE: Effective January 1998 under the managed care program, Georgia Law #12-27-4489, "Co-payments are due at the time services are rendered. Failure to make your required co-payment can and will result in the termination of the subscriber's insurance."

Self Pay:
New patients without insurance are subject to pay no less than $150.00 for their initial visit before seeing the doctor. Any balance due will be billed for payment in full within 30 days after service required.

Established patients without insurance are subject to pay the total fee for their follow-up visits up to $100.00 for services rendered by the doctor. Any balances due will be billed for payment in full within 30 days after service rendered.

Returned Checks:
There is a $30.00 service charge for any checks returned by your banking institution. Returned check fees are payable by cash or money order only. Our office will not schedule any appointments until the balance is paid in full.

Patient's Signature:______________________________Date:_____________________________

Guarantor's Signature:__________________________________

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN:

We wish to stress that the financial responsibility for services rendered rests with the patient or his/her family should the insurance company not pay for services for any reason. If your deductible has not been met, you must pay it at the time of service. If your insurance requires co-payment, this will also be expected on the date the service is rendered.

AUTHORISATION TO PAY BENEFITS TO THE PHYSICIANS AND TO RELEASE INFORMATION:

I hereby authorize payment to be made directly to the physicians of ENT Associates of South Atlanta, LLC for medical services rendered.

Signature_______________________________________ Date:_________________________________

I hereby authorize this practice to release any information regarding my exam or treatment. I have read and understand the above statement. I agree to abide by my insurance carrier's regulations.

Signature_______________________________________ Date:_________________________________

ALLERGY SURVEY

Your response are confidential and may assist the physician in accurate treatment.

Y	N	Do you have fatigue?
Y	N	Do you have frequent headaches?
Y	N	Do you have sneezing, post nasal drainage or itching of the nose?
Y	N	Do you have frequent colds?
Y	N	Do you experience dizziness?
Y	N	Do you get sinus infection every year?
Y	N	Do your eyes itch, water, get red or swell?
Y	N	Do you have recurrent ear infections?
Y	N	Do you have asthma, wheezing, tightness in the chest or chronic cough?
Y	N	Do you have skin problems such as eczema, skin rashes, itching or hives?
Y	N	Do you have indigestion, bloating, diarrhea or constipation?
Y	N	Do your symptoms worsen during a particular season, such as the spring or fall?
Y	N	Do your symptoms change when you go indoors or outdoors?
Y	N	Are your symptoms worse in parks or grassy areas?
Y	N	Are your symptoms worse in the bedroom after going to bed, or in the morning upon rising?
Y	N	Do you awaken in the middle of the night with congestion?
Y	N	Are your symptoms worse when you come into contact with dust?
Y	N	Are your symptoms worse around animals?
Y	N	Do you have any blood relatives with allergies?
Y	N	Do you have any mood swings or feel depressed for no reason?
Y	N	Do you have recurrent infections, jock itch, Athletes foot or fungus under your toenails?
Y	N	Do you develop symptoms after eating or drinking certain foods?

Y	N	Do you sometimes feel stimulated, hyperactive or fatigued after meals?
Y	N	Do you have dark circles under your eyes?
Y	N	Do you have a crease across the bridge of your nose?