

ENT ASSOCIATES OF SOUTH ATLANTA

Otolaryngology, Head & Neck Surgery

Specializing in Surgical Treatment of Epilepsy, Depression, Sleep Apnea, Sinusitis 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 \_\_\_\_\_

Written Communication  
 OK to mail my home office address  
 OK to mail my work/office address  
 OK TO EMAIL  
\_\_\_\_\_

Work Phone \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with call-back number only

OTHER SPOUSE/RELATIVE/OTHER  
(Name) \_\_\_\_\_  
(Name) \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth Date

ENT ASSOCIATES OF ATLANTA  
PATIENT INFORMATION

DATE: \_\_\_\_\_ REFERRING 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 Anesthesia  
( ) 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 ( ) colored ( ) thick ( ) thin ( ) post nasal drip ( ) obstruction ( ) Bleeding ( ) Sneezing  
**MOUTH** NO ( ) Lumps ( ) Dental problems ( ) Tonsillitis ( ) 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 ( ) Apnea ( ) 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 ( ) Vomiting ( ) 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: \_\_\_\_\_

Sleep Multimedia

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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	_____

**E.N.T Associates of South Atlanta**

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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?                   |