Ō·tō·laryn·golō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

M/R RELEASE, MESSAGES, FINANCIAL POLICY

I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE INSURANCE CARRIER(S) VIA FAX OR MAIL. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED. **I AUTHORIZE THE RELEASE** OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE PHYSICIANS INVOLVED IN THE CARE VIA FAX OR MAIL. **I FURTHER AUTHORIZE** OTOLARYNOLOGY ASSOCIATES TO LEAVE THE RESULTS OF THE ABOVE PATIENT'S EXAMINATIONS AND TESTS, INCLUDING MESSAGES, APPOINTMENT REMINDERS, LABORATORY TESTS AND X-RAYS ON THE ANSWERING MACHINE/VOICEMAIL AT THE PHONE NUMBER PROVIDED. **I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS** OF THE HEALTH SERVICES FOR THE ABOVE PATIENT, AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM THE INSURANCE COMPANY. I UNDERSTAND THE DOCTOR'S CHARGE MAY EXCEED THE INSURANCE CARRIER'S PAYMENT AND IF THE CHARGE IS MORE THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THE DIFFERENCE IF FOR ANY REASON THE ABOVE PATIENT'S ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION, ATTORNEY FEES, AND COURT COSTS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

_____ By signing below, I acknowledge that I have received Otolaryngology Associates, LLC* Notice of Privacy Practices ("Notice").

* This includes Whisper Hearing Centers, Biggerstaff & Associates and Balance Point

PRESCRIPTION MEDICATION HISTORY CONSENT

_____ I agree that Otolaryngology Associates, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_______________________________ Date _______________________

Signature (Patient or Authorized Representative)

____

Printed (Patient or Authorized Representative)

____

Printed Patient Name

OTOLARYNGOLOGY ASSOCIATES PHYSICIAN ______ (FOR OFFICE USE ONLY)

PATIENT NAME ______ (LAST) ______ (FIRST) ______ (MIDDLE) ______ INITIAL

PATIENT ADDRESS ______

CITY ______ STATE ______ ZIP ______

PRIMARY ( ) ______ Home / Cell SECONDARY ( ) ______ Home / Cell OTHER ( ) ______ ☐

SOCIAL SECURITY NUMBER ______ - ______ - ______ ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH ______ / ______ / ______ AGE ______ SEX: M / F (CIRCLE ONE)

EMAIL ADDRESS (FOR PATIENT PORTAL ACCESS) ______

RACE: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ More than one race ☐ Unreported/Refused to report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Unreported/Refused to report LANGUAGE: ______

SPOUSE ______ (LAST) ______ (FIRST) ______ (M.I.) ______ (S.S.#) ___ / ___ / ___ (DATE OF BIRTH)

CHILD'S MOTHER/GUARDIAN ______ (LAST) ______ (FIRST) ______ (M.I.) ______ (S.S.#) ___ / ___ / ___ (DATE OF BIRTH)

CHILD'S FATHER/GUARDIAN ______ (LAST) ______ (FIRST) ______ (M.I.) ______ (S.S.#) ___ / ___ / ___ (DATE OF BIRTH)

ADDRESS IF DIFFERENT THAN PATIENT'S ______

REFERRING M.D. ______ / ______ (ADDRESS)

FAMILY M.D. ______ / ______ (ADDRESS)

NOTIFY IN CASE OF EMERGENCY ______ / ______ (RELATIONSHIP) PHONE ( ) ______

PHARMACY ______ LOCATION ______ PHONE ( ) ______

REASON FOR BEING SEEN TODAY ______

ANY HEARING CONCERNS: ☐ YES ☐ NO DO YOU HAVE ANY DIZZINESS: ☐ YES ☐ NO

ANY PROBLEMS WITH ALLERGIES: ☐ YES ☐ NO

****THIS SECTION MUST BE COMPLETED IN FULL, EVEN IF CARD IS COPIED****

PRIMARY INSURANCE CO. ______ Employer: ______

ID# ______ GROUP # ______ POLICY HOLDER'S DATE OF BIRTH ___ / ___ / ___

POLICY HOLDER'S NAME ______ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPARENT

SECONDARY INSURANCE CO. ______ Employer: ______

ID# ______ GROUP # ______ POLICY HOLDER'S DATE OF BIRTH ___ / ___ / ___

POLICY HOLDER'S NAME ______ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPARENT

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HEALTH HISTORY DATA SHEET

(Complete this form in ink) **Please Print**

Provider ______________________ HEIGHT ______________

WEIGHT ______________

FAMILY PHYSICIAN ______________________________

CHECK (√) BELOW ANY ILLNESSES YOU HAVE HAD.

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Bronchitis
- ☐ Cancer - Tumors
  Type__________
- ☐ Chicken Pox
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Disease
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
  Type__________
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Neuritis
- ☐ Obstructive Sleep Apnea
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers (Leg)
- ☐ Ulcers (Duodenal)

List Other Illnesses

____

____

____

____

____

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No

Please Print List Below

____

____

____

____

Are you currently taking any vitamins, herbal supplements or over the counter medications? ☐ Yes ☐ No **Please Print List Below**

____

____

____

____

OPERATIONS Please Print

TYPE	MONTH - YEAR	NAME OF HOSPITAL

FRACTURES Please Print

ALLERGIES CHECK (√) BELOW IF YOU ARE ALLERGIC TO: ☐ **NO ALLERGIES**

- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine
- ☐ Demerol
- ☐ Aspirin
- ☐ Morphine
- ☐ Latex

Please Print Other Drug Allergies Not Listed On The Left ______________________________

____

____

____

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FAMILY HEALTH HISTORY DATA SHEET Physician: ____________

FAMILY HISTORY (CHECK √ BELOW IF ANY OF THE CONDITIONS HAVE OCCURRED ON EITHER SIDE OF PATIENT'S FAMILY)

List Any Other Illnesses

- ☐ Allergies
- ☐ Bleeding Tendencies
- ☐ Blood Disease
- ☐ Bone Disease
- ☐ Cancer or Tumors
- ☐ Cardiovascular Disease (Heart)
- ☐ Congenital Deformities
- ☐ Diabetes
- ☐ Gastrointestinal Disease
- ☐ Kidney Disease
- ☐ Mental Disease
- ☐ Pulmonary Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis

Do you have a pacemaker? ☐ Yes ☐ No

Are you HIV positive? ☐ Yes ☐ No

Smoking Status: ☐ Never Smoker ☐ Current every day smoker ☐ Current someday smoker ☐ Former smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked Start Date: ____________ Quit Date: ____________

Do you use alcohol? ☐ Yes ☐ No Amount per day ____________

Do you use illegal substances? ☐ Yes ☐ No

Have you or anyone in your family had problems with anesthesia? ☐ Yes ☐ No Attend Day Care: ☐ Yes ☐ No

ROS (CHECK √ BOX IF YOU HAVE HAD THESE SYMPTOMS IN THE PAST YEAR)

- Constitutional: ☐ Weight Loss ☐ Fatigue ☐ Fever
- Eyes: ☐ Double or Blurry Vision ☐ Blindness ☐ Red Eyes
- Cardiovascular: ☐ Chest Pain ☐ Shortness of Breath on Exertion ☐ Cyanosis ☐ Ankle Edema ☐ Frequent Urination at Night
- Respiratory: ☐ Shortness of Breath ☐ Cough ☐ Coughing Blood ☐ Wheezing ☐ Use Oxygen
- GI: ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Diarrhea ☐ Indigestion
- GU: ☐ Blood in Urine ☐ Burning ☐ Urinary Infections
- Musculoskeletal: ☐ Muscle Weakness ☐ Pain ☐ Tenderness ☐ Joint Swelling
- Skin: ☐ Rash ☐ Lumps ☐ Sores ☐ Loss of Hair
- Neuro: ☐ Headaches ☐ Blackouts ☐ Paralysis ☐ Numbness ☐ Head Injury
- Psychiatric: ☐ Nervousness ☐ Anxiety ☐ Memory Loss ☐ Sleep Disturbances
- Hematology/Lymphatic: ☐ Anemia ☐ Bruise Easy ☐ Enlarged Lymph Nodes
- Endocrine: ☐ Excessive Thirst ☐ Intolerance of Heat or Cold ☐ High Blood Sugar
- Allergy/Immunologic: ☐ Inhalant or Food Allergy ☐ Itchy ☐ Frequent Infections

Have you ever taken Cortisone? ☐ Yes ☐ No

☐ Orally ☐ Injection

If yes, Month ____________ Year ____________

Please Print Month ____________ Year ____________

Month ____________ Year ____________

VACCINATIONS (Please select the ones you have had)

☐ Mumps ☐ Tetanus ☐ Rubella ☐ Influenza

☐ Pneumococcal ☐ Hepatitis

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OA Physician: ______________________

Contact Information for Protected Health Information

I, ______________________________ (patient's name) DOB: ______________

request that the following methods be adhered to for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnoses, test results, dates of service as described in the Notice of Privacy Practices).

Please check any or all of the three options that apply:

Option A:

☐ OA may disclose information by telephone to people designated below. **This document does not allow the people listed below to receive medical records. For OA to allow non patients to receive medical records, a release of information form must be signed by the patient or their power of attorney.**

Name	Phone Number	Relationship

Option B:

☐ You may leave Protected Health Information on my answering machine/voicemail at this phone number: (   ) ______________________

Option C:

☐ Other ______________________

Document is good for one year from date signed.

______________________ Patient's Printed Name

______________________ Social Security Number

______________________ Patient's Signature (or Guardian if a minor)

______________________ Date

______________________ Witness (optional)

______________________ Date