

Name:  
DOB:  
Chart:  
Age:  
Date:

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### 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.

\_\_\_\_\_  
Signature (Patient or Authorized Representative)

Date \_\_\_\_\_

\_\_\_\_\_  
Printed (Patient or Authorized Representative)

\_\_\_\_\_  
Printed Patient Name

Name:  
DOB:  
Chart:  
Age:  
Date:

**OTOLARYNGOLOGY ASSOCIATES**

PHYSICIAN \_\_\_\_\_

(FOR OFFICE USE ONLY)

PATIENT NAME \_\_\_\_\_ INITIAL \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

PATIENT ADDRESS \_\_\_\_\_ **Last 4 SS#** \_\_\_\_\_

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 \_\_\_\_\_ / \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
(RELATIONSHIP)

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  STEPPAREN

**SECONDARY INSURANCE CO.** \_\_\_\_\_ Employer: \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
POLICY HOLDER'S NAME \_\_\_\_\_  PATIENT  SPOUSE  FATHER  MOTHER  STEPPAREN

Name:  
DOB:  
Chart:  
Age:  
Date:

# O-tō-laryn-golō-gy Associates

ENT & Face, Head & Neck Plastic Surgery  
[www.otolaryn.com](http://www.otolaryn.com)

## HEALTH HISTORY DATA SHEET

(Complete this form in ink) Please Print

Provider \_\_\_\_\_

HEIGHT \_\_\_\_\_

WEIGHT \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

CHECK (✓) BELOW ANY ILLNESSES YOU HAVE HAD.

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Eye Disease             | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Bleeding Tendencies           | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Thyroid                      |
| <input type="checkbox"/> Bronchitis                    | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Measles                  | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Cancer - Tumors<br>Type _____ | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Ulcers (Leg)                 |
| <input type="checkbox"/> Chicken Pox                   | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Ulcers (Duodenal)            |
| <input type="checkbox"/> Depression/Anxiety            | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Neuritis                 | List Other Illnesses                                  |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hepatitis<br>Type _____ | <input type="checkbox"/> Obstructive Sleep Apnea  | _____   |
| <input type="checkbox"/> Diverticulosis                | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Osteoarthritis           | _____   |
| <input type="checkbox"/> Eczema                        | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Pancreatitis             | _____   |
| <input type="checkbox"/> Emphysema                     |  | <input type="checkbox"/> Polio                    | _____   |
|  |  | <input type="checkbox"/> Rheumatic Fever          | _____   |

## 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

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin  |
| <input type="checkbox"/> Sulfa      | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> Latex    |
| <input type="checkbox"/> Demerol    |                                   |

Please Print Other Drug Allergies Not Listed On The Left

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name:  
DOB:  
Chart:  
Age:  
Date:

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## FAMILY HEALTH HISTORY DATA SHEET

Physician: PriDrName

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

List Any Other Illnesses

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Bleeding Tendencies            | <input type="checkbox"/> Gastrointestinal Disease |
| <input type="checkbox"/> Blood Disease                  | <input type="checkbox"/> Kidney Disease           |
| <input type="checkbox"/> Bone Disease                   | <input type="checkbox"/> Mental Disease           |
| <input type="checkbox"/> Cancer or Tumors               | <input type="checkbox"/> Pulmonary Disease        |
| <input type="checkbox"/> Cardiovascular Disease (Heart) | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Congenital Deformities         | <input type="checkbox"/> 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

## VACCINATIONS (Please select the ones you have had)

Mumps  Tetanus  Rubella  Influenza

If yes, Month \_\_\_\_\_ Year \_\_\_\_\_

Pneumococcal  Hepatitis

Please Print Month \_\_\_\_\_ Year \_\_\_\_\_

Month \_\_\_\_\_ Year \_\_\_\_\_

Name:  
DOB:  
Chart:  
Age:  
Date:

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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