DUBLIN
Ear, Nose, and Throat
Associates, P.C.

# PATIENT INFORMATION

****PLEASE ENTER ALL INFORMATION AS IT APPEARS ON INSURANCE****

_____ **Preferred Name:** _____
**Last Name** **First Name** **MI**

Mailing Address: _____ City: _____ Zip: _____

**Best # to be reached: (_____)-_____-_____** 2nd #: **(_____)-_____-_____**

**DOB:** _____/_____/_____ **Social Security #:** _____-_____-_____ Email: _____

Employer:_____ Work #: (_____)-_____-_____

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**SEX:** M F **MARITAL STATUS:** Married Single Divorced Separated Widowed

**RACE:** Black or African American White Hispanic Other: _____

**ETHNICITY:** Hispanic or Latino/Spanish Not Hispanic or Latino Other: _____

**LANGUAGE:** English Spanish Other: _____

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Primary (PCP) Doctor: _____ Referring Doctor: _____

**PHARMACY INFORMATION:**

PHARMACY: _____CITY:_____ PHONE #: (_____)-_____-_____

**EMERGENCY CONTACT:**

Name: _____Relation: _____ PHONE #: (_____)-_____-_____

****GUARANTOR INFORMATION** (*For Minors Only*)

Parent's Name: _____ DOB: _____/_____/_____

Social Security #: _____-_____-_____ *Parent Employer: _____

**INSURANCE INFORMATION**

Primary: _____ Policy #: _____ Grp: _____

Secondary: _____ Policy #: _____ Grp: _____

*************If policyholder/responsible party are different from the patient, please answer the questions below*************

Name: _____ DOB: _____ Social Security #: _____

Address: _____ Relationship to patient: _____

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

# NOTICE OF PRIVACY PRACTICES
# PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications to protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

**Signature:** _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

# FINANCIAL POLICY

Thank you for choosing *Dublin Ear, Nose, and Throat Associates, PC* (Dublin ENT). We are committed to the success of your medical treatment, and we strive to offer excellent care in a patient friendly environment. We recognize that healthcare is expensive, insurance requirements are frustrating and discussing payment arrangements when you don't feel well may be unpleasant. Nevertheless, prompt payment of charges helps us expedite your care so we ask you to review our financial policies. As your health care provider, our relationship is with you…our patient and not with your insurance company. Your insurance plan is a contract between you, your insurance company and/or your employer. Our office is a not a party to that contract or any possible restrictions imposed by it. While we will make every effort to obtain appropriate payment from your insurance carrier, payment for services rendered is ultimately your responsibility.

**Payment for Services:** Copays will be collected at check-in, as well as any balance due on the account. We will pre-collect the estimated patient responsibility amount for surgeries and office procedures.

**Insurance:** You will be required to update your insurance information at least once each year, but we may ask you to provide your insurance card more frequently. Please notify our office immediately if you change insurance carriers, drop coverage, received new cards or in any way experience a change to your coverage. Failure to do so may result in insurance claim denials that cause all charges to become your full responsibility. Please know the benefits, limitations, and responsibilities of your insurance plan.

**Referrals and Authorizations:** If your plan(s) require a referral from your Primary Care Physician (PCP), please make sure one has been provided prior to your appointment. We must have a current referral to prevent your insurance carrier from denying payment for services you receive with us. In addition, our office policy requires a new referral from your PCP prior to being seen initially and if there has been a gap in care of more than 3 years.

**Co-Pays, Deductible, Co-Insurance and Pre-Determination of Benefits:** We participate with many health plans and file charges with those plans as a courtesy. Most health plans require us to collect charges they deem to be patient responsibility in the form of co-pays, deductibles, and coinsurance. We must also collect payment directly from the patient for services the plan does not cover. If Dublin ENT does not participate with your insurance plan, payment in full is required at the time of service. Our charges are usual and customary for our area. If your insurance ultimately denies responsibility for services you receive, you are responsible for payment. If you have a Health Savings Account (HAS), Health Reimbursement Account (HRA) or a Flexible Spending Account (FSA), we will provide all documentation necessary for you to receive appropriate reimbursement; however, payment is still required at time of service.

**Uninsured Patients:** Payment is due at the time services are provided. A minimum deposit of $150.00 (determined by services required) will be required prior to the appointment. This payment will be applied to your total balance due upon check-out for all services rendered during the visit.

**Past Due Balances:** Balances that are not paid within 30 Days from the date of services are considered past-due. If your insurance company has not responded to our request for payment within 30 Days, we will ask for your assistance in obtaining payment from the carrier and/or to make a payment on the balance. Balances that are not paid in 90 Days of the date of service will be forwarded to a collection agency. By signing the below, you agree to allow Dublin ENT billing department to contact you by telephone or text message to any telephonic number provided including wireless or mobile telephone numbers. I agree to any method of contact to these numbers, such as a dialing service or prerecorded message. Collection agency and any associated legal fees may be added to the account. Patients with past-due balances will be required to make payment arrangements before additional services will be scheduled.

**Credit & Debit Card Transactions:** Due to fees incurred by our practice by accepting credit and debit cards as a form or payment we have instated a 3% surcharge policy on all credit & debit cards used as a form of payment. This fee is 5% for Care Credit Cards.

**No-Show and Late Cancellation Fees:** Because cancelled appointment slots for surgeries and other procedures are difficult to fill without the adequate notice, a fee in the amount of $25 will be charged for appointments that are not cancelled at least 24 hours prior to the appointment time.

**Signature:** _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Dublin Ear, Nose, and Throat to discuss or release any of your records concerning you medical condition with any members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **DO NOT** authorize Dublin Ear, Nose, and Throat to release any or all information concerning my medical care to any individual except as set forth above.

_____ I **AUTHORIZE** Dublin Ear, Nose, and Throat to release any or all information concerning my medical care to the following individuals,

_____

Name Relationship to Patient

_____

Name Relationship to Patient

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## MEDICAL RECORD REQUEST AUTHORIZATION

**I, _____, hereby Request and Authorize my healthcare provider(s) to release records pertaining to my care & treatment to:**

**Dublin Ear, Nose, and Throat Associates, PC**
**102 Fairview Park Drive Dublin, Georgia 31021**

*I understand that the Federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that this acknowledgement will be valid for the duration of my treatment on matters related to the services provided to me. I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*

***By signing below I confirm that I have given permission for Dublin Ear, Nose, and Throat Associates, P.C. to obtain these requested medical records.***

**Patient Signature:**_____ **DOB:** _____

### USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____

*(Date this authorization is revoked by individual)* *(Signature of individual or legally authorized Representative)*

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

# PATIENT QUESTIONNAIRE
# CHIEF COMPLAINT/HISTORY OF ILLNESS

**Reason for today's visit:** _____

How long have you had this problem? _____

What makes it better? _____

What makes it worse? _____

What other symptoms are you having? _____

## MEDICAL HISTORY *(Please check any illness that you have)*

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Cancer
- ☐ Chronic Neck/Back Pain
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Heart Attack
- ☐ Heart Failure (CHF)
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Schizophrenia
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other

**FOR CHILDREN ONLY** *(Please answer for children under 18 years old)*

**Type of Birth:**

☐ Vaginal Delivery ☐ Full Term (_____weeks) Any Complications at Birth? **YES** **NO**

☐ C-Section ☐ Premature (_____weeks)

## PAST SURGICAL HISTORY *(Please check any surgeries that you have had.)*

- ☐ Appendix Removal
- ☐ Low Back Surgery
- ☐ Brain Surgery
- ☐ Carotid Artery Surgery
- ☐ Colon Removal
- ☐ Coronary Angioplasty/ Stent
- ☐ Ear Tubes
- ☐ Gallbladder
- ☐ Heart Bypass/Valve
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Lung Surgery
- ☐ Mastectomy
- ☐ Neck Spine Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Prostate Removal
- ☐ Repair of Broken Bones
- ☐ Sinus Surgery
- ☐ Skin Cancer Removal
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Vascular Bypass
- ☐ Other _____

## FAMILY HISTORY *(Check all illnesses that run in your family.)*

- ☐ Alcoholism
- ☐ Anesthesia Reaction
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Psychiatric Illness
- ☐ Sickle Cell Anemia
- ☐ Stroke

## SOCIAL HISTORY *(Circle One)*

Occupation: _____ **Full Time** **Part Time** **Retired** **Disabled** **Unemployed**

How much alcohol do you drink each day? _____

Have you ever used tobacco? **YES** **NO** Do you currently use any tobacco products? **YES** **NO**

How much & for how long? _____ per/day for _____ yrs.

Did you Quit? **YES** **NO** How long ago? _____

What kind of tobacco do you use? **Cigarettes** **Cigar** **Pipe** **Chewing Tobacco** **Skoal**

Are you exposed to second hand smoke? **YES** **NO**

Do you have any drug addictions? **YES** **NO**

Are you up to date on your immunizations? **YES** **NO**

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

# PATIENT MEDICATION RECORD

☐ **PATIENT TAKES NO ROUTINE MEDICATIONS** *(Please List Any PRN or "As Needed" Medications below)*

| DATE | PRESCRIPTION | DOSAGE | FREQUENCY |
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## DRUG ALLERGIES (PLEASE LIST):

☐ NO KNOWN DRUG ALLERGIES

_____

_____

## MARK ANY OF THESE BLOOD THINNERS THAT YOU TAKE:

☐ ASPIRIN ☐ VITAMIN E ☐ XARELTO
☐ LOVENOX ☐ PLAVIX ☐ HEPRIN
☐ GOODY POWDERS ☐ COUMADIN ☐ NSAIDS (MOTRIN/ ALEVE/ IBUPROFEN/ ADVIL/ NAPROXEN)

## ARE YOU ALLERGIC TO?

☐ MEDICAL TAPE
☐ IODINE
☐ LATEX

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

# REVIEW OF SYSTEMS

*(Select all symptoms that apply)*

## ENT:

- ☐ Hearing loss
- ☐ Nose Drainage
- ☐ Voice Change
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Snoring
- ☐ Dizziness
- ☐ Facial Pain
- ☐ Sore Mouth/Throat
- ☐ Bad Breath
- ☐ Ear Drainage
- ☐ Swallowing Pain
- ☐ Difficulty Swallowing
- ☐ Hoarseness

## CONSTITUTIONAL:

- ☐ Chills
- ☐ Excessive Fatigue
- ☐ Fever
- ☐ Weight Gain _____ lbs in the past _____ weeks.
- ☐ Weight Loss _____ lbs in the past _____ weeks.

## EYES:

- ☐ Double Vision
- ☐ Drainage from Eyes
- ☐ Glasses/Contacts
- ☐ Blindness

## ALLERGY/IMMUNOLOGY:

- ☐ Seasonal Allergies
- ☐ Allergy tested in the past
- ☐ Latex allergy
- ☐ Blood transfusion in the past

## RESPIRATORY:

- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

## CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Edema of the legs
- ☐ Trouble breathing while lying flat
- ☐ Palpitations

## GENITOURINARY:

- ☐ Pain during urination
- ☐ Blood in urine
- ☐ Bed wetting

## GASTROINTESTINAL:

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea

## NEUROLOGICAL:

- ☐ Fainting spells
- ☐ Headaches
- ☐ Paralysis of an arm or leg
- ☐ Seizures
- ☐ Tremor

## MUSCULOSKELETAL:

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle pain

## SKIN:

- ☐ Growths on the skin
- ☐ Rash
- ☐ Non-healing wounds

## HEMATOLOGIC:

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymph nodes swelling (neck, groin area, or underarm)

## PSYCHIATRIC:

- ☐ Clinical depression
- ☐ Nervousness/Anxiety
- ☐ Increased stress level
- ☐ Other psychiatric disorder:_____

**I confirm the above information is true and correct.**

_____ _____

Patient Signature Date