DUBLIN ENT 478.272.8382

PATIENT REGISTRATION

Last name: _____ First Name: _____MI:_____

Mailing Address: _____ City: _____ Zip: _____

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

DOB: _____/_____/_____ Social Security #: _____-_____-_____ Primary Doctor: _____

Email: _____Employer:_____ Referring Doctor: _____

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: _____

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

Insurance: _____ Policy #: _____

Secondary: _____ Policy #: _____

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

Name: _____ DOB: _____ Social Security #: _____

Address: _____ Relationship to patient: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS; HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUT OFFICE BOOKKEEPER. ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE AND A $30 FEE WILL BE CHARGED ON ALL RETURN CHECKS. YOU ARE RESPONSIBLE FOR VERIFYING WHETHER OR NOT DUBLIN ENT IS CONSIDERED "IN-NETWORK" WITH YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR NOTIFYING DUBLIN ENT OF ANY CHANGES IN INSURANCE COVERAGE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO PAUL D. KELLAM, JR., M.D./THOMAS C. MULLIS, M.D./DIANE W. DAVIS, M.D. FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 USC 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION

Express Consent for Communication: By signing this form, I expressly consent and authorize DUBLIN EAR, NOSE, AND THROAT and its affiliates and agents, including any collection agency or debt collector hired by them, to communicate with me for any reason related to the services provided by DUBLIN EAR, NOSE, AND THROAT, including collection of amounts owed for said services, This communication may be made using an automatic telephone system or an artificial or prerecorded voice at the telephone number(s) I provided to DUBLIN EAR, NOSE, AND THROAT and its affiliates and agents and also any telephone number assigned to a cellular telephone service or any service for which I am charged for the call. In addition, I further expressly consent and authorize DUBLIN EAR, NOSE, AND THROAT and its affiliates and agents, including any collection agency or debt collector hired by them, to communicate with me at any phone number or email address or other unique electronic identifier or mode that I provided to DUBLIN EAR, NOSE, AND THROAT or its affiliates or agents at any time, or any phone number or email address or other unique electronic identifier or mode DUBLIN EAR, NOSE, AND THROAT or its affiliates or agents finds or obtains on its own which is not provided by me.

***SIGNATURE: _____ Date: _____**

DUBLIN EAR, NOSE, AND THROAT ASSOCIATES, P.C.
102 FAIRVIEW PARK DRIVE
DUBLIN, GEORGIA 31021
(478) 272-8382

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

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.

Consent to Wireless Telephone Calls

I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf to contact me on cell phone/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication.

Signature: _____ Date: _____

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

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
_____	_____
Name	Relationship to Patient
_____	_____
Patient Signature	Date
_____	_____
Patient Name	DOB

DUBLIN EAR, NOSE, AND THROAT ASSOCIATES, P.C. PATIENT QUESTIONNAIRE

Patient name: _____

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

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.

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

DUBLIN EAR, NOSE, AND THROAT ASSOCIATES, PC
MEDICATION RECORD

NAME: _____ DOB: _____

DATE	PRESCRIPTION	DOSAGE	FREQUENCY

DRUG ALLERGIES (PLEASE LIST):

_____

_____

☐ NO KNOWN DRUG ALLERGIES

CIRCLE ANY OF THESE BLOOD THINNERS THAT YOU TAKE

ASPIRIN LOVENOX GOODY POWDERS VITAMIN E

PLAVIX COUMADIN XARELTO HEAPRIN

NSAIDS (MOTRIN/ ALEVE/ IBUPROFEN/ ADVIL/ NAPROXEN)

ARE YOU ALLERGIC TO?

☐ MEDICAL TAPE

☐ IODINE

☐ LATEX

REVIEW OF SYSTEMS

(Circle all symptoms that apply)

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

ENT:

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

ALLERGY/IMMUNOLOGY:

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

CARDIOVASCULAR:

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

RESPIRATORY:

Cough Coughing up blood Shortness of breath Wheezing

GASTROINTESTINAL:

Abdominal pain Constipation Diarrhea Heartburn Nausea

GENITOURINARY:

Pain during urination Blood in urine Bed wetting

MUSCULOSKELETAL:

Joint pain Joint stiffness Muscle pain

NEUROLOGICAL:

Fainting spells Headaches Paralysis of an arm or leg Seizures Tremor

SKIN:

Growths on the skin Rash Non-healing wounds

PSYCHIATRIC:

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

HEMATOLOGIC:

Easy bleeding Easy bruising Lymph nodes swelling in your neck, groin area, or underarm

The above information is true and correct.

_____ _____

Patient Signature Date