SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

PATIENT REGISTRATION INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Gender:** ❑ Male ❑ Female

Race: _____ **Preferred Language:** _____ **Ethnicity:** ❑ Hispanic ❑ Non Hispanic

Address: _____

City: _____ **State:**_____ **Zip:** _____ **Phone:** _____

Email: _____

Emergency Contact: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

PRIMARY Insurance Carrier: _____ ❑ HMO ❑ PPO ❑ EPO ❑ POS

Insurance ID: _____ **Are you the policy holder?** ❑ Yes ❑ No

If NO, please provide information on the primary policy holder:

Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Claims Address: _____

SECONDARY Insurance Carrier: _____ ❑ HMO ❑ PPO ❑ EPO ❑ POS

Insurance ID: _____ **Are you the policy holder?** ❑ Yes ❑ No

If NO, please provide information on the primary policy holder:

Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Claims Address: _____

Patient is financially responsible unless the patient is a minor child or guardian. This is a consent prepared according to guidelines presented by the Texas Family Code (Section 35.01).

❑ I will be held responsible ❑ The patient is a minor or guardian

If the patient is a minor or guardian, please indicate the patient relationship to the responsible party:

❑ Child ❑ Other, please specify: _____ Responsible party's date of birth: _____

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

CURRENT MEDICAL INFORMATION

Who is your preferred pharmacy? _____

Pharmacy Address: _____

City: _____ **State:**_____ **Zip:** _____ **Phone:** _____

Who referred you to our office? _____

Who is your primary care physician (PCP)? _____

What is your current height? _____ **What is your current weight?** _____

What is the reason for your visit?

What previous treatment, tests, procedures, or surgeries have you completed for this condition?

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

Please list all medications the patient is currently taking, including dosage and frequency. ***If the patient is currently taking more than 10 medications, please do not fill out this section, and bring a list to the appointment.***

Please list any allergies the patient has had a reaction to, as well as the reaction.

1600 W COLLEGE ST, STE 555, GRAPEVINE, TX 76051 | PHONE: 817.329.6798 | FAX: 817.549.3320
WWW.MANOLIDISENT.COM

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

Please indicate "Yes" to indicate whether the patient currently has any of the following.

❑ Yes	❑ Chills ❑ Fever ❑ Night Sweats	❑ Yes	Bluish Skin Color (Cyanosis)
❑ Yes	Fatigue	❑ Yes	Swelling (Edema)
❑ Yes	Weight ❑ Gain ❑ Loss	❑ Yes	Abdominal Pain
❑ Yes	Double Vision (Diplopia)	❑ Yes	Bloating
❑ Yes	Dry Eyes	❑ Yes	Constipation
❑ Yes	Vision Changes (Visual Loss)	❑ Yes	Heartburn
❑ Yes	Ear Drainage (Discharge)	❑ Yes	Vomiting
❑ Yes	Hearing Loss	❑ Yes	Difficulty Urinating (Dysuria)
❑ Yes	Ear Pain (Otalgia)	❑ Yes	Blood in Urine (Hematuria)
❑ Yes	Ringing in the Ears (Tinnitus)	❑ Yes	Cold Intolerance
❑ Yes	Dizziness / Vertigo	❑ Yes	Heat Intolerance
❑ Yes	Voice Change	❑ Yes	Increased Thirst (Polydipsia)
❑ Yes	Difficulty Swallowing (Dysphagia)	❑ Yes	Difficulty Speaking (Dysarthria)
❑ Yes	Sore Throat (Pharyngitis)	❑ Yes	Fainting (Loss of Consciousness)
❑ Yes	Asthma	❑ Yes	Tingling Arms/Legs (Paresthesias)
❑ Yes	Cough	❑ Yes	Tremors
❑ Yes	Difficulty Breathing (Dyspnea)	❑ Yes	Anxiety (Psychiatric/Emotional)
❑ Yes	Blood in Sputum (Hemoptysis)	❑ Yes	Depression (Psychiatric/Emotional)
❑ Yes	Snoring	❑ Yes	Skin ❑ Lesion ❑ Rash
❑ Yes	Wheezing	❑ Yes	Bone/Joint Pain (Symptoms)
❑ Yes	Chest Pain	❑ Yes	Neck Pain (Stiffness)
❑ Yes	Shortness of Breath (Orthopnea)	❑ Yes	Easy Bleeding
❑ Yes	Irregular Heartbeat/Palpitations	❑ Yes	Easy Bruising

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

PAST MEDICAL HISTORY

Please list any conditions that the patient is actively being treated for as well as the date of onset.

Please list any previous surgeries including the date of procedure.

Please describe any family members with significant medical problems.

SOCIAL HISTORY

Does the patient smoke cigarettes?	❑ Yes	Frequency: _____
Does the patient smoke cigars?	❑ Yes	Frequency: _____
Does the patient chew tobacco?	❑ Yes	Frequency: _____
Does the patient drink alcohol?	❑ Yes	Frequency: _____
Does the patient use illicit drugs?	❑ Yes	Frequency: _____

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Federal privacy guidelines, HIPAA, prevent Texas Health Care (THC) and Dr. Spiros Manolidis from disclosing protected health information (PHI) to anyone other than the patient.

I, the undersigned, hereby authorize Texas Health Care (THC) and Dr. Spiros Manolidis to disclose PHI from my medical or financial record to the following person and/or persons by any of the following means: mail, fax and/or orally.

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

My authorization extends to any and all records, unless otherwise marked below:

❏ Office Visit Notes ❏ Statements of charges or payments ❏ Consultation Reports

❏ Operative Reports ❏ Discharge Summary ❏ Photographs or images

❏ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

❏ Other (must be specific): _____

I authorize Texas Health Care (THC) and Dr. Spiros Manolidis to disclose my PHI in the following manner:

❏ Phone ❏ Leave Detailed Messages on Voicemail ❏ Text ❏ Mail ❏ E-Mail ❏ Fax

This authorization is given freely with the understanding that I may revoke this authorization in writing at any time, but not retroactively, and Texas Health Care (THC), Dr. Spiros Manolidis, and his staff are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED PATIENT/GUARDIAN NAME **DATE OF BIRTH**

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

TEXT COMMUNICATION CONSENT FORM

Our office uses text messaging to communicate with patients regarding scheduling and to allow communication with our staff and Dr. Manolidis. These messages could contain personal health information (PHI) and other confidential information. While any electronic communication can be intercepted, text messages (SMS) are not encrypted and not HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant and thus information is easier to obtain if these messages are intercepted.

DO NOT TEXT OUR OFFICE IN THE CASE OF A MEDICAL EMERGENCY, PLEASE CALL 911.

❏ **I ACCEPT TEXT MESSAGE COMMUNICATIONS**

Regular text and data rates apply and you are responsible for any such rates and charges. Please also understand that your messages may not be viewed right away, especially in the event that you send messages outside of business hours, on the weekend, or on a holiday. Dr. Manolidis's texting number is 817-527-1302. Please save this number in your phone as you may receive texts from this number.

❏ **I <u>DO NOT</u> ACCEPT TEXT MESSAGE COMMUNICATIONS**

By signing this waiver, you release and hold harmless Dr. Manolidis and his staff from any liability for the release of information pertaining to your medical care as specified above.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED PATIENT/GUARDIAN NAME **DATE OF BIRTH**

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Please read:

Texas Health Care (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices and have reviewed the office's Notice of Privacy Practices, which explains how your medical information will be used and disclosed. You are entitled to receive a copy of the Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED PATIENT/GUARDIAN NAME **DATE OF BIRTH**

SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

CONSENT FOR DIAGNOSTIC TESTS/PROCEDURES THAT MAY BE NECESSARY TO FULLY DIAGNOSE AND TREAT YOUR CONDITION

We are pleased you have chosen Dr. Manolidis to assist in your care. He feels that a patient presenting to our office with sinus, nose, throat, hearing or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures, which he may feel is medically necessary. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. For example, insurance companies may consider the nasal endoscopy and laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or co-insurance. The following list are the most commonly performed test/procedures that Dr. Manolidis may feel is medically necessary to perform, but by no means is this a comprehensive list:

- Nasal Endoscopy (31231)
- Laryngoscopy (31575)
- Cerumen Impaction Removal (69210)
- Binocular Microscopy (92504)
- Cavity Care (69220 and 69222)
- Foreign Body Removal (69200)

Please note that we collect all co-insurance and unmet deductibles at the end of your visit. Should you have questions regarding any proposed test/procedure, potential risks and benefits, possible complications, possible risks and benefits of not undergoing this procedure, alternative methods, or your financial responsibility of the proposed test/procedure, please ask Dr. Manolidis during his explanation of the test/procedure and prior to the physician performing the test/procedure. No guarantee or assurance can be given as to the results that may be obtained from this test/procedure. Please sign below to acknowledge that you have read the above and understand your financial liability.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

PRINTED PATIENT/GUARDIAN NAME _____ **DATE OF BIRTH** _____