PEACHTREE E.N.T. & FACIAL PLASTICS
PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY TODAY'S DATE _____

PATIENT NAME: _____ DOB: _____ RACE: _____ SEX: M F

LOCAL MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE#: _____ SOCIAL SECURITY#: _____

EMAIL ADDRESS: _____

EMPLOYER NAME: _____ WORK PHONE#: _____

CELL PHONE#: _____ MARITAL STATUS: S M W D

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

PART TIME RESIDENTS PLEASE PROVIDE YOUR ALTERNATE MAILING ADDRESS:

ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP CODE: _____

IF PATIENT HAS A LEGAL GUARDIAN OR IS A MINOR PLEASE PROVIDE THE FOLLOWING

GUARDIAN OR PARENT NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE #: _____ CELLPHONE #: _____

REFERRED FROM: ☐ YELLOWPAGES ☐ FRIEND ☐ INSURANCE ☐ DOCTOR ☐ NEWSPAPER/PUBLICATION ☐ BILLBOARD
REFERING DOCTOR NAME: _____ **PHONE#:** _____

EMERGENCY CONTACT: NEAREST RELATIVE, NEIGHBOR, OR FRIEND NOT LIVING WITH YOU (IN CASE YOU CAN'T BE REACHED)

NAME: _____ PHONE#: _____

PRIMARY INSURANCE: _____ **ID#** _____

SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

SECONDARY INSURANCE: _____ **ID#** _____

SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

TREATMENT AUTHORIZATION

I hereby give PeachTree ENT & Facial Plastics consent for medical treatment.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Today's Date: _____

Peachtree E.N.T & Facial Plastics

Patient History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____/_____/_____

Family Doctor: _____ Dr.'s Phone : _____

Pharmacy: _____ Pharmacy #: _____

What are you here for today? _____

_____

Current Medications: Include **ALL** prescriptions, over the counter meds, vitamins, minerals & herbals:
Specifically: Coumadin, Plavix, Aspirin, etc. Any blood thinning medications.

Drug Name	Dose(mg)	How often	Drug Name	Dose (mg)	How often

Medical History: *list all medical problems you are being treated for:* _____

_____

_____

Allergies/Intolerance: **Reactions:**

_____ _____

_____ _____

_____ _____

Please check if allergic to the following: ___Latex ___Adhesive tape ___Novocain ___Lidocaine ___Epinephrine

Surgeries – Check if you have had any of the following surgeries

__ Tonsils/Adenoids __Ear/Mastoid __Nasal sinus/Septum/Polyps __Head/neck cancer or surgery __Salivary glands

List all other surgeries/complications here: _____

_____

Hospitlizations: Check if only for surgery_____

Otherwise list hospitalizations here: _____

_____

Family History: circle one of the following:

Father: alive/deceased

Mother: alive/deceased

Siblings: alive/deceased _____# of boys _____# of girls

Natural children: alive/deceased _____# of boys _____ #of girls

NAME_____ DATE_____

SOCIAL HISTORY

Do you smoke cigarettes? Yes or No If yes, _____packs per day for _____ # of years
Did you ever smoke? Yes or No If yes, _____ # of years ago _____ packs per day
Do you smoke cigars or a pipe? Yes or No If yes, _____ # per day for _____ # of years
Do you chew or dip tobacco? Yes or No If yes, _____ # of years Quit? How long _____
Do you drink alcoholic beverages? Yes or No How much_____
Do you use or have you ever used illegal substances Yes or No
Do you drink caffeine products? Yes or No Type? _____ How much _____

Do you have an Advance Directive (Living Will, POA) Yes or No? If yes, please provide a copy to be scanned (and returned to you) and the name and phone number of your designated agent:

_____

Have you ever had difficulty with anesthesia? Yes or No If yes, please explain: _____

_____

Have you ever been diagnosed with a bleeding disorder? Yes or No If yes, please explain:

_____

Are you presently under the care of a cardiologist? Yes or No If yes, please state medical reason:
_____ and give cardiologist name/#:

_____

Do you have to take antibiotics prior to invasive procedures? (due to pacemaker, mitral valve prolapse, Joint replacements, etc) Yes or No If yes, please explain: _____

Are you on any blood thinners, including aspirin? Yes or No If yes, _____

Any additonal Info you want to provide? _____

_____

Phone Messages: Please indicate if you prefer ____ Brief or ____Detailed phone messages

Rx History Consent: Permission if granted by the above named patient/ POA/ or legal guardian to view the patient's prescription history from external sources. This consent allows prescriptions to be sent to your pharmacy electronically. Please initial _____

Physician Absentee Guidelines: Dr. Weisenburger is in a solo practice. He does not have another doctor to cover for him and cannot be available at all times. Therefore, in the case of an emergency, please seek medical attention and appropriate treatment at the nearest emergency room. Your initials below indicate you understand and agree to follow the necessary obligation. Please initial _____

Patient Name_____ **Date**_____

PLEASE MARK EACH ONE THAT APPLIES TO YOUR APPOINTMENT AND/OR PERMANENT MEDICAL HISTORY

CONSTITUTIONAL
- __ WEIGHT GAIN
- __ FEVER
- __ WEAKNESS
- __ WEIGHT LOSS
- __ NIGHT SWEATS
- __ RESTLESS SLEEP
- __ ALWAYS TIRED
- __ ANTIBIOTICS REQUIRED FOR DENTAL CARE
- __ EXERCISE TOLERANCE

EYES
- __ DRY EYES
- __ ITCHY EYES
- __ WATERY EYES
- __ PRESSURE IN EYES
- __ BLURRED VISION
- __ LOSS OF VISION
- __ EYE PAIN
- __ GLAUCOMA
- __ CATARACTS

EARS RT LT OR BOTH
- __ EAR PAIN
- __ DISCHARGE FROM EARS
- __ ITCHY EARS
- __ WAX
- __ FEELING OF FULLNESS
- __ HEARING LOSS
- __ RINGING IN EARS
- __ DIZZINESS

NOSE
- __ OBSTRUCTION
- __ DRIPPING
- __ CHANGES IN SMELL
- __ BLEEDING
- __ SNEEZING
- __ SINUS PRESSURE
- __ HEAD COLD

THROAT
- __ CLEARING
- __ HOARSENESS
- __ SORE THROAT OR THROAT PAIN
- __ DRY MOUTH
- __ SNORING
- __ CHOKING
- __ TIGHTNESS

RESPIRATORY
- __ SHORTNESS OF BREATH
- __ CHEST CONGESTION
- __ COUGH
- __ EXCESS MUCOUS
- __ WHEEZING
- __ STOP/HOLD BREATH WHILE SLEEPING
- __ GASP FOR BREATH WHEN AWAKE
- __ FALL ASLEEP WHILE DRIVING
- __ ASTHMA
- __ TB BRONCHITIS PNEUMONIA

ALLERGY/IMMUNOLOGIC
- __ SWOLLEN LIPS/TONGUE
- __ SKIN RASH
- __ ITCHING
- __ THROAT TIGHTNESS
- __ ALLERGY TO DYE FOOD OR MEDS
- __ HEPATITIS AIDS OR HIV+

DERMATOLOGY
- __ RASH
- __ ITCHY SKIN
- __ HIVES
- __ BLEEDING
- __ NON-HEALING LESION OR SORE

ENDOCRINOLOGY
- __ SLEEP DISTURBANCE
- __ INTOLERANCE TO HEAT OR COLD
- __ NIGHT SWEATS
- __ THYROID DISEASE
- __ DIABETES INSULIN DEPENDENT
- __ DIABETES NON-INSULIN DEPENDENT
- __ CHANGES IN APPETITE OR WEIGHT

NEUROLOGY
- __ HEADACHES
- __ SEIZURES
- __ DIZZINESS
- __ FACIAL WEAKNESS
- __ FAINTING SPELLS
- __ FREQUENT MORNING HEADACHES
- __ FACIAL WEAKNESS/PARALYSIS
- __ FACIAL NUMBNESS
- __ FACIAL PAIN
- __ TREMORS
- __ MEMORY LOSS

GASTROENTEROLOGY
- __ NAUSEA
- __ HEARTBURN OR INDIGESTION
- __ ACID REFLUX
- __ VOMITING
- __ TROUBLE SWALLOWING
- __ CHANGE IN BOWEL HABITS
- __ DIARRHEA OR CONSTIPATION

CARDIOLOGY
- __ CHEST PAIN
- __ PALPITATIONS
- __ HEART MURMUR
- __ PAIN IN JAW OR NECK
- __ HIGH BLOOD PRESSURE
- __ ABNORMAL HEART RHYTHM
- __ CONGESTIVE HEART FAILURE
- __ MITRAL VALVE REPLACEMENT
- __ **PACEMAKER PATIENT (PROVIDE PACEMAKER CARD)**
- __ LEG PAIN WHEN WALKING
- __ TACHYCARDIA
- __ FAINTING
- __ VERTIGO
- __ EDEMA

PSYCHIATRIC
- __ DEPRESSION
- __ THOUGHTS OF SUICIDE
- __ FEELING ANXIOUS
- __ IRRITABILITY
- __ MOOD SWINGS
- __ NIGHTMARES

MUSCULOSKELETAL
- __ NECK PAIN
- __ JAW PAIN
- __ JAW CLENCHING
- __ PAIN IN JAW JOINTS
- __ JOINT REPLACEMENT
- __ ARTHRITIS
- __ GOUT
- __ SWELLING
- __ REDNESS

PEACHTREE E.N.T. & FACIAL PLASTICS, P.A.

FINANCIAL POLICY

PLEASE READ CAREFULLY

As your physician PeachTree Ent & Facial Plastics, PA is committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENTS FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, Mastercard, Visa, and Discover. Returned checks are subject to a service charge of $25.00 or 5% whichever amount is greater, And you will lose privilege to write checks in our office.

NO SHOWS— Patients who do not cancel appointments may be charged a $25.00 no show fee and may also be discharged from the practice after the second no show.

MEDICARE— Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare Provider we will file your Medicare claim for you. If you have a secondary insurance, please check with the front desk to see if we are participating with your insurance company.

MEDICARE REPLACEMENTS - We will file your claim with Medicare Replacements. You are responsible for any co-pay and deductible at time of service.

BLUECROSS/BLUESHIELD PPO & PPC COVERAGE - CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with this insurance company, we will file your insurance.

MEDICAID - There is a $3.00 co-pay for each visit.

WORKERS' COMPENSATION - It is your responsibility to call your employer to get the visit authorized, we will file your company's insurance. In the event you fail to prosecute this claim for Workers' Compensation for this illness or the condition is determined not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. **Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e. yearly physicals, x-rays, labs, hearing tests).**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not the insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY ON THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

FINANCIAL AGREEMENT ADDENDUM - Statement for any balances due will be mailed three (3) times. If no response is received from the patient or guarantor, the account will be sent to collections. Should it be necessary to forward an account to collections, all charges incurred during the collection process (postage fees, collection fees, etc.) will be the responsibility of the patient or guarantor. The signature below confirms you have read and understand this policy.

_____ _____

Signature of patient / POA / legal guardian — Date

_____ _____

Signature of Witness — Date

PeachTree E.N.T. & Facial Plastics, P.A.

Notice of Privacy Practices Acknowledgement

I understand that, under the health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of PeachTree E.N.T. & Facial Plastics, P.A.'s privacy practices available in the waiting room containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, unless you are bound to abide by such restrictions.
I may also give permission to any person(s) allowing them access to my personal health information.

PLEASE LIST NAMES: (Spouse, Children, etc.)

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and received a copy of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____
(Patient or Legal Guardian)

Relationship to Patient: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____

CP-2686