Hot Springs Ear, Nose & Throat Clinic

Date: _____

Patient Health Information

Patient Name: _____
First Middle Last Nickname

Date of Birth: _____ Age: _____ Sex: Male Female

Referring Physician: _____City: _____

Family Physician: _____City:_____

What is the main reason for your visit?_____

_____

When did it start, and what if anything makes it better or worse?_____

_____

Past Medical History of Patient

_____Diabetes
_____Ulcers
_____High Blood Pressure
_____Heart Disease
_____Bleeding Problems
_____Tuberculosis
_____Asthma
_____Reflux
_____Liver Disease
_____Thyroid Disorder
_____Pacemaker
_____AIDS/HIV exposure
_____Seizures
_____Stroke
_____Cancer – Type_____
_____Blood Transfusion/When_____
_____Seasonal Allergies (runny nose, itchy eyes, nasal congestion)

Would you like more information on allergies and allergy testing? _____ Yes _____No

Family History

Do you have a family history of?

_____Hearing Loss
_____Cancer
_____Diabetes
_____Heart Disease

Pediatric History

For patients under 3 years old ONLY

Birth Weight_____lbs.
Premature? Yes No
Current Weight: _____lbs.

Surgical/Hospitalizations History
Please give approximate year

Any Problems with anesthesia? Yes No If Yes, please explain_____

_____

Social History

Do you live alone? _____ Marital Status: _____ Occupation: _____

Do you smoke or use tobacco?

Yes, I have smoked _____ packs of cigarettes per day for _____ years.

Yes, I smoke cigars or a pipe.

Yes, I chew tobacco.

No, I quit _____ years ago. At the time I was smoking _____ packs per day for _____ years. At the time I chewed tobacco for _____ years.

No, I have never smoked.

No, I have never chewed tobacco.

Do you drink alcohol?

No, never/rarely

No, but I used to

Yes:____ Daily _____ 1 or more times per week ____ 1 or more times per month

Review of Symptoms

Do you currently have or have had problem with:

CONSTITUTIONAL	YES	NO	GASTORINTESTIONAL	YES	NO
Fever			Indigestion or pain with eating		
Weight loss			Nausea		
Excessive Fatigue			Vomiting		
Night Sweats			Liver Disease		
EYES			Jaundice		
Glasses-Date of last exam			Ulcers / Gastritis		
Infections			**GENITOURINARY**		
Injuries			Urinary Tract Infections		
Glaucoma			Kidney Stones		
Cataracts			**MUSCULOSKELETAL**		
EAR,NOSE,THROAT&MOUTH			Cramping		
Hearing Loss			Arm or Leg Pain		
Pain			Joint swelling		
Ear Infections			Arthritis		
Ringing in ears Left Right or Both			**INTEGUMENTARY**		
Balance Disturbance (Dizziness)			Skin Disease / Cancer		
Nosebleeds			**CARDIOVASCULAR**		
Nasal Congestion			Chest pain / Angina		
Nasal Drainage			High Blood Pressure		
Inability to smell / taste			Irregular Pulse		
Mouth Sores			Date of last EKG:		
Sore Throats			Heart Murmur		
RESPIRATORY			High Cholesterol		
Asthma			Swelling in feet or hands		
Emphysema			**NEUROLOGICAL**		
Chronic Cough			Fainting spells or “blacking out”		
Shortness of Breath			Seizures		
Lung Cancer			Double or blurred vision		
Date of last chest X-Ray:			Face Weakness		
PSYCHIATRIC			**ALLERGIC / IMMUNOLOGIC**		
Anxiety			Food Allergies		
Depression			Inhalant (nasal) allergies		
Other Psychiatric			**HEMATOLOGIC / LYMPHATIC**		
ENDOCRINE			Anemia		
Diabetes			Hemophilia		
Thyroid Disease			Bleeding Tendencies		

Patient Information ***(please fill out form completely)***

Patient Name: _____
First Middle Last

Address:_____

City: _____ State:_____Zip Code:_____

Home #:_____Cell #_____ Date of Birth:_____Age:_____

Social Security #: _____ Marital Status: M S D W or Minor

Employer/Occupation: _____Work #: _____

Emergency Contact Person_____**Relationship:**_____
_____

Phone #: _____

Responsible Party Information: (*MUST BE FILLED OUT IF PATIENT IS A MINOR)*

Relationship to Patient: Self Parent Other:_____

Name:_____
_____

Address: _____
_____

City: _____State:_____Zip Code:_____

Home #: _____Cell #:_____Work #:_____
_____

Date of Birth:_____ Social Security #: _____Marital Status: M S D W

Employer/Occupation :_____ Email Address:_____

Spouse Information: Name:_____Date of Birth:_____
_____

Social Security #:_____Phone #:_____

Employer/Occupation: _____Work #:_____

Insurance Information:

Primary Insurance

Name of Policy Holder:_____ Policy Holder's Date of Birth:_____

ID/Policy #:_____

Secondary Insurance

Name of Policy Holder:_____Policy Holder's Date of Birth:_____

ID/Policy #:_____

Hot Springs Clinic of Otolaryngology

Current Medications

Patient Name: _____ Date: _____

Please list all medication the patient is taking.

Medication	Date	Date	Date	Date	Date	Date

Pharmacy

What Pharmacy do you use? _____

Location of Pharmacy: _____

Phone # to Pharmacy: _____

List any drug allergies: _____

_____

Release of Information

I authorize Hot Springs Ear, Nose and Throat Clinic to release any information to any physician involved in my care, including diagnosis and records of any treatment of examination rendered to me.

Assignment of Benefits

I authorize and request payments of insurance benefits be made directly to Hot Springs Ear, Nose and Throat Clinic. I further certify that I have provided a complete list of insurance companies with which I have medical coverage.

Hot Springs ENT Clinic is "Out of Network" with Cigna. This may result in higher cost to the patient if you have health insurance with Cigna.

Consent of Treatment

I authorize Hot Springs Ear, Nose and Throat Clinic and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order related services on my behalf.

Financial Agreement

Payment is due in full at the time of service. Acceptable methods of payment are cash, personal check, MasterCard, Visa, and Discover. There will be a fee of $25.00 for returned checks. If you are unable to keep a scheduled appointment please give 24 hours advanced notice or there may be a missed appointment fee of $25.00 applied to your account.

Insurance Information

We do not accept any Medicare Replacement Policies. Example, but not limited to: Humana, Windsor, Medicare Advantage and United Health Care Medicare Solutions. Unfortunately, if your insurance has changed to a Medicare Replacement Plan, Hot Springs Ear, Nose and Throat Clinic will no longer be able to render services to you.

Your insurance policy is a contract between you and you your insurance: Neither Dr.Monte nor Hot Springs Ear, Nose and Throat Clinic are involved.

At times Dr. Monte is not able to be on call, it may be necessary for you to contact your primary care provider or go to the nearest emergency room.

Collections

You agree, in order for us to service your account or to collect any amount owed us, we may call any number associated with your account, including wireless telephone numbers which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre- recorded / artificial voice and/ or the use of an automated dialing device.

These authorizations remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that "your office or agent" may contact me as described above.

If you fail to pay your account in full or make timely payments we will refer your account to a collection agency. You will be responsible for paying the fee that the collection agency charges for collection of your debt. The amount of that fee is 25% of your debt. That 25% will be added to your debt and collected by the collection agency. By Signing below, you understand and agree to pay that fee. Also, please understand that you are still responsible for any court cost or recovery cost associated with collection of your debt.

Should my account become overdue and subsequently transferred to a collection agency, I agree to pay a collection agency fee equal to 25% of my debt owed your office in ADDITION to the debt I owe. I understand that I am also responsible for any court cost or recovery cost associated with the collection of this debt.

Patient name: _____ Date: _____

Signature of patient/guarantor: _____

Office Representative: _____ Date: _____

Hot Spring Clinic of Otolaryngology
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____ have received a copy of Hot Springs Clinic of Otolaryngology's Notice of Privacy Practices.

_____ _____

Signature and Date of Birth of Patient or Guardian Date

I give my permission to discuss or release all clinic and financial information to the following persons:

Spouse _____
Children_____
Caregiver/Other_____
Parent/Guardian_____
Okay to leave message on answering machine

DO NOT release any or my information to the following person(s):_____

_____

Authorization and Release

I authorize the release of any medical information needed to determine benefits payable for medical services to the insurance carrier and its agents or other third party payers. I authorize the release of necessary medical information to the referring and/or the referred to physician.

I authorize and request my insurance company to pay surgical and/or medical benefits directly to Hot Spring Clinic of Otolaryngology for services rendered. I understand and agree that the entire bill is my responsibility, regardless of my insurance coverage. In the event that the insurance check is mailed directly to me, I realize that it is for immediate payment to Hot Springs Clinic of Otolaryngology.

I understand that my insurance carrier may pay less than the actual billed amount for my services. I agree to pay any balance applied to my deductible, coins or copayment for medical services rendered by this clinic. *(Note: In a single parent family, the parent bringing the child to the office for treatment is recognized as the party assuming the cost of the treatment.)*

I agree to pay my account at the time of service. If for any reason the is a balance owing on my account, I agree to pay the balance promptly or make payment arrangements.

_____

Signature of patient or guardian Date