EAR, NOSE & THROAT ASSOCIATES

Jin S. Lim, MD - Rebecca M. Beckman, AuD - Alyson Dixon, AuD
7001 Heritage Village Plaza - Suite 170 - Gainesville, VA 20155
Phone: 703-468-2205 Fax: 703-468-2216

PATIENT INTAKE FORM

First Name: _____ Last Name: _____ Birth Sex: Female Male

Date of Birth: _____ Marital Status: _____ Race: _____

Email Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

Which phone number do you prefer? Home / Mobile / Work (please circle one)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____

Emergency Contact Relationship to Patient: _____

Occupation: _____ Employer: _____

Pharmacy: _____ Pharmacy Phone Number: _____

Medication Allergies:

_____

_____

If patient is a minor:

Guardian #1 Name:_____ Guardian #1 Phone Number: _____

Guardian #2 Name: _____ Guardian #2 Phone Number: _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Name & DOB of Insured, if other than the patient: _____

Secondary Insurance: _____ Member ID: _____

Name & DOB of Insured, if other than the patient: _____

I have read the above statements and I understand my responsibilities. I acknowledge that Ear, Nose & Throat Associates will scan this document and destroy the original. I agree the scanned document is the same as the original.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

EAR, NOSE & THROAT
ASSOCIATES

Patient Name: _____
Patient DOB: _____
Today's Date: _____

GENERAL MEDICAL HISTORY

Please check all that apply:

Age related macular degeneration		Alzheimer's disease		Anemia	
Arthritis		Asthma		Autistic Disorder	
Autoimmune disease		Barrett's esophagus		Benign enlargement of prostate	
Carotid artery stenosis		Cataract		COPD (chronic pulmonary disease)	
Congestive heart failure		Cystic fibrosis		Dementia	
Esophageal reflux		Glaucoma		History of stroke	
HIV		HPV (human papilloma virus)		Headache disorder	
Heart attack		History of anxiety		History of atrial fibrillation	
History of depression		History of Type 1 diabetes		History of Type 2 diabetes	
History of hypertension		History of leukemia		History of lymphoma	
History of malignant melanoma		History of renal failure		History of sickle cell anemia	
Hypercoagulability		Immune system disorder		Irritable bowel syndrome	
Migraines		Multiple sclerosis		Neutropenia	
Obstructive Sleep Apnea		Osteoarthritis		Osteoporosis	
Parkinson's disease		Primary fibromyalgia syndrome		Pulmonary embolism	
Rheumatoid arthritis		Seizure disorder		Sjogren's Syndrome	
Spinal stenosis		Suspected head and neck cancer		Systemic lupus erythematosus	
Thrombocytopenia		Thyroid disease			
Other:					

PAST SURGERIES

Please check all that apply and include the date of surgery:

Appendectomy		Cataract extraction		Cesarean section	
Coronary angioplasty		Coronary artery bypass graft		Cosmetic surgery	
Excision of breast lump		Glaucoma surgery		History of colectomy	
Hysterectomy		Implantation of cardiac pacemaker		Removal of gallbladder	
Total knee replacement		Total replacement of hip		Total shoulder replacement	
Other:					

EAR, NOSE & THROAT
ASSOCIATES

Patient Name: _____
Patient DOB: _____
Today's Date: _____

EAR, NOSE & THROAT MEDICAL HISTORY

Please check all that apply:

Acoustic neuroma		Acute otitis externa		Acute otitis media	
Allergic rhinitis		Basal cell carcinoma of skin		Branchial cleft cyst	
Cholesteatoma		Deviated nasal septum		Enlargement of tonsil or adenoid	
Epistaxis		Eustachian tube disorder		Fracture of face bones	
Fracture of nasal bones		Gastroesophageal reflux disease		History of hearing loss	
Loss of sense of smell		Malignant melanoma of head and neck		Malignant neoplasm of skin	
Mastoiditis		Metastatic malignant neoplasm to lymph nodes of next		Neoplasm of parotid gland	
Oral cavity, dental and salivary gland disorder		Otosclerosis		Perforation of nasal septum	
Polyp of nasal sinus		Polyp of vocal cord		Primary malignant neoplasm of accessory sinus	
Recurrent respiratory papillomatosis		Sialoadenitis		Sialolithiasis	
Sinusitis		Sleep Apnea		Squamous cell carcinoma of skin	
Stenosis of trachea		Subglottic stenosis		Suspected head and neck cancer	
Thyroglossal duct cyst		Thyroid nodule		Tinnitus	
Tonsillitis		Ulcer of mouth		Vertigo	
Vocal cord paralysis		Other:			

EAR, NOSE & THROAT SURGICAL HISTORY

Adenoidectomy		Balloon sinuplasty		Closed reduction of nasal fracture	
Excision of lesion of oral cavity		Excision of submandibular gland		Excision of thyroglossal duct cyst	
Functional endoscopic sinus surgery		History of tonsillectomy		Mastoidectomy	
Modified radical neck dissection		Myringotomy and insertion of tympanic ventilation tube		Nasal septoplasty	
Parathyroidectomy		Parotidectomy		Procedure on head and/or neck	
Reduction of nasal turbinate		Removal of acoustic neuroma		Stapedectomy	
Thyroidectomy		Total laryngectomy		UPPP	
Other:					

EAR, NOSE & THROAT ASSOCIATES

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Today's Date: _____

EAR, NOSE & THROAT FAMILY HISTORY

Otitis media (middle ear infection)		Sinusitis		Smoking	
Thyroid Cancer		Thyroid Disease			
Other:					

SOCIAL HISTORY

What is your tobacco usage?

- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Cigar Smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

How many times in the past year have you had 4 or more drinks in a day? _____

Do you consume alcohol?

- ☐ Yes, less than 1 drink per day
- ☐ Yes, 1-2 drinks per day
- ☐ Yes, 3 or more drinks per day

Do you use vaping products? Yes_____ No _____

Do you use smokeless tobacco?

- ☐ None
- ☐ Dip
- ☐ Chew
- ☐ Snuff
- ☐ Nicotine Gum
- ☐ Nicotine Patch

I have read the above statements and I understand my responsibilities. I acknowledge that Ear, Nose & Throat Associates will scan this document and destroy the original, and agree the scanned document is the same as the original.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I was offered and have received a copy of the “Notice of Privacy Practices” for Ear, Nose & Throat Associates, PC (the "Notice"). I understand that as provided in the Notice the terms of the notice may change. I understand that if the Notice changes, I will receive a revised copy. I am aware that the Notice is posted in the office, on the website, and that copies are available at any time. I understand that I may ask questions of Ear, Nose & Throat Associates if I do not understand any information in the Notice of Privacy Practices. I understand that I may access my medical records at any time and that I may copy and/or inspect my protected health information (PHI) to be used or disclosed in accordance with Ear, Nose & Throat Associates’ policy. I understand that Ear, Nose & Throat Associates, PC may charge me for copies of such records or completion of medical record forms; however, a fee schedule will be provided to me. I understand that Ear, Nose & Throat Associates, PC has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

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CONSENT FOR TREATMENT: I authorize Ear, Nose & Throat Associates to provide medical treatment to myself and/or my dependent.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Ear, Nose & Throat Associates for services provided under their care.

RELEASE OF MEDICAL INFORMATION: I authorize Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

COLLECTION OF CO-PAYS AND DEDUCTIBLES: I understand that per agreements with my insurance carrier, I am required to pay any applicable copayments at the time of service. I understand that I am responsible for any deductible and/or balance my plan indicates on their Explanation of Benefits. I acknowledge that balances are due within 30-60 days from the date of service. I understand that the billing office is available Monday through Friday, from 8:00 am to 4:00 pm EST and can be reached at 703-468-2205.

FINANCIAL RESPONSIBILITY: I understand that Ear, Nose & Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I understand that if I do not have insurance, payment is expected in full at the time of service, and prior to any procedure. Should collection proceedings or other legal action become necessary to collect an overdue account, I understand that Ear, Nose & Throat Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I understand and agree to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by Ear, Nose & Throat Associates. I understand and agree that should Ear, Nose & Throat Associates be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

REFERRALS/AUTHORIZATIONS: I understand that my insurance company may require that I obtain a referral from my physician prior to being seen by a specialist. I understand that it is my responsibility to obtain the referral and/or authorization prior to my visit.

MISSED APPOINTMENTS: I understand that Ear, Nose & Throat Associates requires at least 24 hours notice if I must cancel an appointment. I realize that failure to do so will result in a $50 “no show” fee. I understand that if I fail to cancel an appointment at least 24 hours in advance a second time, I will be charged a $75 “no show” fee. I understand that this fee will NOT be covered by my insurance policy.

RETURNED CHECKS: Our office will charge $25 for any check that is returned for insufficient funds.

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AUTHORIZATION FORM FOR USE & DISCLOSURE OF

PROTECTED HEALTH INFORMATION (PHI)

The Notice of Privacy Practices provides information about how Ear, Nose & Throat Associates may use and disclose my PHI. Disclosures may be made to family and friends related to my health. Ear, Nose & Throat Associates will only disclose information relevant to current treatment. By signing below I authorize Ear, Nose & Throat Associates, PC to only disclose health care information to the following individuals (list all that apply):

	Name of Individual	In Person	By Phone	Phone Number
Spouse Name		☐	☐	
Parent(s) Name		☐	☐	
Sibling(s) Name		☐	☐	
Other		☐	☐	

This authorization will last one year from the date of signature, unless I enter an expiration date here: _____.

Ear, Nose & Throat Associates has my permission to leave medical information or messages on my:

- Cell Phone Voicemail: _____
- Home Phone Voicemail: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____