ENT OF GEORGIA
EAR, NOSE & THROAT | NORTH

Email Address: _____

Name: _____ Sex: [ ] M [ ] F

Address: _____ Date of Birth: _____

_____ Marital Status: [ ] Married [ ]Single [ ] Divorced

City,State, Zip Code: _____ Referring Physician: _____

Phone: _____ [ ] Home [ ] Work [ ] Cell Primary Physician: _____

Phone: _____ [ ] Home [ ] Work [ ] Cell Primary Language Spoken: _____

Race: _____ CONTACTS

PATIENT INFORMATION

_____

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

_____

Phone: _____ Pharmacy Name & Number: _____

Employer: _____

_____

GUARANTOR
[ ] Same as Patient

EMPLOYMENT
Employer: _____

Name: _____ Phone: _____

Address: _____ Phone: _____

_____ Social Security: _____

City, State, Zip Code: _____ Date of Birth: _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security #: _____

Insurance Company: _____ Insured ID #: _____

Policy Group: _____ Date of Birth: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security #: _____

Company: _____ Insured ID #: _____

Policy Group #: _____ Date of Birth: _____

Financial Responsibility

Copayments _____ (Initial)
All office visits require a copayment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post operative visits.

Deductible _____ (Initial)
A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service.
An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a copayment is required for the visit. In addition, some services and all procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company and are billed as surgery.

Diagnostic Procedure Consent ____ (Initial)
Your visit today may include a scope being place in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an INVASIVE OR SURGICAL PROCEDURE. Depending on the specifics of your particular policy, your insurance carrier will pay all, part, or none of the cost of this procedure. It is the responsibility of you, the insured, to be aware of the limits of coverage prior to this procedure. Any charges not covered by the insurance carrier will be the responsibility of the patient. YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.

No Show ____ (Initial)
Patients who fail to show for their scheduled appointment, procedure, or surgery and did not notify the office within 24 hours prior to the appointment, shall be subject a No Show penalty of $25.00 for missed appointments, $150.00 for office procedures, and $150.00 for surgery.

Guarantee of Payment for Services & Assignment of Benefits ____ (Initial)
It is the policy of the office that you must pay for services when rendered except in cases of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, copayments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections.
I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of this claim.

Insurance Coverage ____ (Initial)
I understand that my eligibility for coverage by _____ has not been verified at the time of my appointment, but I want to receive medical services from Dr. _____.

I am aware that when the insurance is verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver ____ (Initial)
I understand that if the Referral from the Primary Care Physician's Office is not received before my appointment date, I agree to pay for all services rendered on the day of the visit

_____ _____
Patient Signature (Guardian if patient is a minor) Date

ENT of Georgia North, LLC
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that ENT of Georgia has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996(HIPAA).

As a patient of ENT of Georgia, I understand and acknowledge the following:
1. ENT of Georgia has a privacy policy in effect in their office.
2. ENT of Georgia has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. ENT of Georgia has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign the bottom acknowledging that you have been advised of the privacy policy implemented by ENT of Georgia and have read and understood the acknowledgement form,. If you desire a copy of the Privacy Policy, please request one at this time.

___ No, I do not want a copy, but acknowledge the Privacy Policy exists.
___ Yes, I do want a copy of the Privacy Policy

_____
Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, ENT of Georgia will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize ENT of Georgia to contact me in the following ways (check those which you authorize):

__ Home phone	__Voicemail OK
__ Work phone	__ Voicemail OK
__Cell phone	__Voicemail OK
__Fax	__ Text OK
__E-Mail	Email Address: _____

ENT of Georgia does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, ENT of Georgia does not endorse the use of email communication with patients.

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize ENT of Georgia to discuss matters related to my condition/care with the following:

_____ _____
Patient's representative name Relationship to patient

_____ _____
Signature of patient (Guardian if patient in a minor) Date

Welcome to ENT of Georgia. Our goal is to provide you and your family with the highest of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all pages of the form below. Our staff would be glad to help you if necessary. The care we give you can be no better than the information your provide.

Name _____ Age: _____ Date of Birth: _____
First MI Last MM/DD/YYYY

Gender ( ) Male ( ) Female

Who sent you to us today? _____

This person is: ( ) Primary Physician
( ) Other Physician
( ) Non-physician healthcare provider
( ) Friend/Other

Primary Physician (name and phone number)

_____

_____

Pharmacy Name and Phone Number

_____

Please name the major problem or symptom that brings you to us today: _____

Please describe the history of your present illness in detail:

_____

_____

_____

_____

_____

Rate the severity of today's symptoms on a 1-10 scale (10=worst): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far?

( ) X-Ray ( ) Ultrasound ( ) Hearing Test ( ) NONE
( ) CT Scan ( ) Swallow Study ( ) Biopsy
( ) MRI ( ) Allergy Testing ( ) Other _____

What treatments have been tried so far (include any operations done for this illness)?

( ) Antibiotics ( ) Pain Medications
( ) Allergy Medications ( ) Other _____
( ) Reflux Medications ( ) NONE

Please check those symptoms below which apply to your current complaint:

( ) Headache ( ) Loss of smell/taste ( ) Heartburn
( ) Decreased vision ( ) Hearing loss ( ) Neck mass/swollen glands
( ) Eye pain ( ) Ringing in ears ( ) Snoring
( ) Double vision ( ) Ear pain ( ) Stop breathing during sleep
( ) Nasal congestion ( ) Ear drainage ( ) Sleepy in the daytime
( ) Facial pain ( ) Dizzy/off balance ( ) Throat Pain
( ) Nasal discharge ( ) Ear fullness/pressure ( ) Neck Pain
( ) Post-nasal drip ( ) Difficulty swallowing ( ) NONE
( ) Frequent sneezing ( ) Can't clear throat
( ) Nasal obstruction ( ) Cough
( ) Nosebleed ( ) Hoarseness

Review of Systems

Please check the symptoms below which apply to YOU, and you are CURRENTLY experiencing:

( ) Check here if none of the below symptoms apply to you

GENERAL:
- ( ) Fever/Chills
- ( ) Weight loss
- ( ) Night Sweats

EYES:
- ( ) Light bothers eyes
- ( ) Irritated eyes
- ( ) Eyes crust/drain

CARDIOVASCULAR:
- ( ) Chest Pain
- ( ) Irregular hearbeat

RESPIRATORY:
- ( ) Shortness of breath
- ( ) Wheezing
- ( ) Cough up blood

GASTROINTESTINAL:
- ( ) Abdominal pain
- ( ) Bloody/black stool
- ( ) Nausea/vomiting
- ( ) Diarrhea
- ( ) Yellow Jaudice
- ( ) Indigestion

GENITOURINARY:
- ( ) Painful urination
- ( ) Weak urine stream
- ( ) Blood in urine

MUSCULOSKELETAL:
- ( ) Painful/swollen joints
- ( ) Back Pain

SKIN:
- ( ) Rash
- ( ) Hair/nail problems
- ( ) Flaking/peeling skin

NEUROLOGIC:
- ( ) Weakness
- ( ) Shaking/tremor
- ( ) Fainting

PHYSCHOLOGICAL:
- ( ) High stess/anxiety
- ( ) Depression
- ( ) Mood swings

ENDOCRINE:
- ( ) Cold intolerance
- ( ) Heat intolerance
- ( ) Frequent thirst

BLOOD:
- ( ) Anemia
- ( ) Bruise easily
- ( ) Prolonged bleeding
- ( ) HIV Risk Factors

Past Medical History

Please check the below illnesses you have or have had in the past:

EYES:
- ( ) Glaucoma
- ( ) Cataract
- ( ) Macular degeneration

CARDIOVASCULAR:
- ( ) High blood pressure
- ( ) Past heart attack
- ( ) Prior stroke
- ( ) Blocked arteries
- ( ) Heart failure
- ( ) Mitral valve prolapse
- ( ) Past bypass surgery
- ( ) Have pacemaker
- ( ) Prior angioplasty

RESPIRATORY:
- ( ) Obstructive sleep apnea
- ( ) Asthma
- ( ) COPD/emphysema
- ( ) Tuberculosis
- ( ) Pneumonia
- ( ) Use of oxygen at home

GASTOINTESTINAL:
- ( ) Reflux
- ( ) Hiatal hernia
- ( ) Hepatitis A
- ( ) Hepatitis B
- ( ) Hepatitis C

MUSCULOSKELETAL:
- ( ) Fibromyalgia
- ( ) Gout
- ( ) Arthritis

NEUROLOGIC:
- ( ) Seizure Disorder
- ( ) Parkinson's disease
- ( ) Spinal Injury
- ( ) Head Injury
- ( ) Meningitis

PSYCHIATRIC:
- ( ) Mental health problems
- ( ) Anxiety
- ( ) Depression
- ( ) INFECTIONS:

ENDOCRINE:
- ( ) Low thyroid
- ( ) Overactive thyroid
- ( ) Thyroid nodule
- ( ) Thyroid cancer
- ( ) Diabetes - diet control
- ( ) Diabetes - oral meds
- ( ) Diabetes - insulin

IMMUNOLOGIC:
- ( ) HIV Positive

CD4 count: ____ Viral load: ____

Do you have a history of cancer (circle one)? YES NO

If yes, please specify: _____

Other Significant Illness: _____

_____

_____

Vaccinations:

Have you had a **pneumonia vaccination?** ( ) YES ( ) NO DATE: _____

Have you had a **flu vaccine**(within 12 months)? ( ) YES ( ) NO DATE: _____

Medications (include vitamins, supplements, herbals)

( ) I consent to **ALL** electronic Prescriptions

List ALL Medications you take:

Name of Medication:	Dosage:

Allergies List all FOOD, CONTACT, INHALANT, & DRUG Allergies

( ) I HAVE NO KNOWN DRUG ALLERGIES

( ) Latex Allergy

Name:	Reaction:

Surgical History:

( ) I HAVE HAD NO OPERATIONS/SURGICAL PROCEDURES

( ) PE Tubes	( ) Septoplasty	( ) Airway Surgery
( ) Middle Ear Surgery	( ) Turbinate Reduction	( ) Thyroid Surgery
( ) External Ear Surgery	( ) Sinus Surgery	( ) Parotid Surgery
( ) Tonsillectomy	( ) Rhinoplasty	( ) Neck Surgery
( ) Adenoidectomy	( ) Sleep Apnea	( ) Mastoidectomy
	( ) Vocal Cord Surgery	( ) Tympanoplasty

( ) Other (Include date) _____

_____

_____

Family History: Please check those illnesses that are present in your immediate blood relatives (parents, siblings, children):

( ) Unknown/Adopted	( ) High Blood Pressure	( ) Hearing Loss
( ) Heart attack/disease	( ) Diabetes	( ) Sickle Cell/trait
( ) Blocked arteries	( ) Thyroid problems	( ) Bleeding problem
( ) Past stroke	( ) Cancer	( ) Asthma
( ) Allergies		( ) NONE

( ) Other: _____

Social History:

What type of work/school do you do? _____

Who lives with you at home?

( ) Live Alone	( ) With Other Family Member(s)	( ) With a Dog
( ) With Spouse/Partner	( ) With Friend(s)/Roomate(s)	( ) With a Cat
( ) With Parents	( ) Shelter	( ) Other: _____
( ) With Children	( ) In an Assisted Living Facility	

Have you ever or do you currently smoke or use tobacco products in any form? ( ) YES ( ) NO

Cigarette/E-Smoke/Cigar/Chewing (circle) ____ packs/day Quit? ____ Years Smoked _____ packs/day

Are you exposed to second hand smoke? ( ) YES ( ) NO

Do you consume:			
Alcoholic Beverages	( ) YES	( ) NO	_____/day/week/month (circle)
Water	( ) YES	( ) NO	_____ Glasses per day
Caffeine(coffee/tea/soda)	( ) YES	( ) NO	_____ Beverages per day

Is there any chance you may be pregnant? ( ) YES ( ) NO ( ) N/A

Height: _____ Weight: _____

_____ _____

Patient Signature (Guardian if patient is a minor) **Date**