North Georgia ENT

Dr. Sanjay Athavale, *M.D.*
Sarah Dryanski, *Au.D.*

Name: _____ Email Address: _____

Address: _____ Sex: ☐ M ☐ F

_____

City, State, Zip Code: _____ DOB: _____

Phone: _____ ☐ Home ☐ Work ☐ Cell Marital Status: ☐ Married ☐ Single ☐ Divorced

Phone: _____ ☐ Home ☐ Work ☐ Cell Referring Physician: _____

Race: _____ Primary Physician: _____

Primary Language: _____

PATIENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Phone: _____

Employer: _____

EMERGENCY CONTACTS

Primary Name and Number: _____

_____

_____

AUTHORIZED ADULT(S) TO ACCOMPANY MINOR

Authorized Adult Information

Full Name: _____ Relationship to Minor: _____ Phone Number: _____

Parent/Guardian Signature: _____

Authorized Adult Information

Full Name: _____ Relationship to Minor: _____ Phone Number: _____

Parent/Guardian Signature: _____

Authorized Adult Information

Full Name: _____ Relationship to Minor: _____ Phone Number: _____

Parent/Guardian Signature: _____

GUARANTOR

☐ Same as Patient

Name: _____

Address: _____

City, State, Zip Code: _____

EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

DOB: _____

PRIMARY INSURANCE

☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security #: _____

Insurance Company: _____ Insurance ID #: _____

Policy Group: _____ DOB: _____

SECONDARY INSURANCE

☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security #: _____

Insurance Company: _____ Insurance ID #: _____

Policy Group: _____ DOB: _____

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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 copayments 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 such.

Diagnostic Procedure Consent: _____ (Initial)

Your visit today may include a scope being placed 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 your responsibility, as 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 do not notify the office within 24 hours prior to the appointment shall be subject to 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 and 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 incurred herein. 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 $25.00 surcharge for collections.

I hereby authorize payment of the insurance benefits 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 has not been verified at the time of my appointment, but I want to receive medical services from Dr. [Line].

I am aware that when the insurance is verified, there is a disclaimer that states that 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: _____

970 Joe Frank Harris Parkway, Suite 330, Cartersville, GA 30120
Phone: (770) 217-6224 • www.drathavale.com • Fax: (706) 216-4830

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PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

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

As a patient of North Georgia ENT, I understand and acknowledge the following:

1. North Georgia ENT has a Privacy Policy in effect in its office.
2. North Georgia ENT 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. North Georgia ENT has made me aware that, as a patient, I am entitled to a copy of the 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 North Georgia ENT and have read and understood the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

☐ No, I do not want a copy, but I acknowledge that 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 health care, North Georgia ENT will need to contact me to remind me of appointments, provide test results, give instructions or provide other information.

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

☐ Home Phone ☐ Voicemail OK

☐ Work Phone ☐ Voicemail OK

☐ Cellphone ☐ Voicemail OK ☐ Text OK

☐ Fax

☐ Email Address: _____

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

I understand that North Georgia ENT 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 North Georgia ENT to discuss matters related to my condition/care with the following:

_____ _____

Patient Representative's Name Relationship to Patient

_____ _____

Signature of Patient (Guardian If Patient Is a Minor) Date

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ADVANCE CARE

Do you/the patient have an advance directive? ☐ Yes ☐ No

Designee Name: _____

Designee Phone Number: _____

Do you/the patient have a living will? ☐ Yes ☐ No

Select which statement(s) best reflect your/the patient's wishes on advance care:

☐ Do not intubate: Does not wish to have a breathing tube to save your/their life.

☐ Do not resuscitate: Does not wish to have chest compressions or a defibrillator to restart your/their heart.

☐ Full cardiopulmonary resuscitation: Wishes for full resuscitation efforts to be made.

Name (First, Mid, Last): _____ Age: _____ Date of Birth (Month/Day/Year): _____

Gender: ☐ Male ☐ Female

Who sent you to us today? _____

This person is: ☐ Primary Physician ☐ Other Physician ☐ Non-Physician Health Care 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
☐ CT Scan
☐ MRI
☐ Swallow Study
☐ Biopsy
☐ Hearing Test
☐ Allergy Test
☐ Other
☐ None

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

- ☐ Antibiotics
- ☐ Allergy Medications
- ☐ Other
- ☐ Pain Medications
- ☐ Reflux Medications
- ☐ None

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

- ☐ Headache
- ☐ Decreased Vision
- ☐ Eye Pain
- ☐ Double Vision
- ☐ Nasal Congestion
- ☐ Facial Pain
- ☐ Nasal Discharge
- ☐ Postnasal Drip
- ☐ Frequent Sneezing
- ☐ Nasal Obstruction
- ☐ Nosebleed
- ☐ Loss of Smell/Taste
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Dizzy/Off-Balance
- ☐ Ear Fullness/Pressure
- ☐ Difficulty Swallowing
- ☐ Can't Clear Throat
- ☐ Cough
- ☐ Hoarseness
- ☐ Heartburn
- ☐ Neck Mass/Swollen Glands
- ☐ Snoring
- ☐ Stop Breathing During Sleep
- ☐ Sleepy in the Daytime
- ☐ Throat Pain
- ☐ Neck Pain
- ☐ None
- ☐ Other: _____

REVIEW OF SYSTEMS

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

☐ Check here if none of the below symptoms apply to you.

GENERAL:
- ☐ Fever/Chills
- ☐ Weight Loss
- ☐ Night Sweats

GASTROINTESTINAL:
- ☐ Abdominal Pain
- ☐ Bloody/Black Stool
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Yellow Jaundice
- ☐ Indigestion

NEUROLOGICAL:
- ☐ Weakness
- ☐ Shaking/Tremor
- ☐ Fainting

EYES:
- ☐ Light Bothers My Eyes
- ☐ Irritated Eyes
- ☐ Eyes Crust/Drain

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Irregular Heartbeat

RESPIRATORY:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Coughing Up Blood

GENITOURINARY:
- ☐ Painful Urination
- ☐ Weak Urine Stream
- ☐ Blood In Urine

MUSCULOSKELETAL:
- ☐ Painful/Swollen Joints
- ☐ Back Pain

SKIN:
- ☐ Rash
- ☐ Hair/Nail Problems
- ☐ Flaking/Peeling Skin

PSYCHOLOGICAL:
- ☐ High Stress/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 illnesses below that 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

GASTROINTESTINAL:
- ☐ 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

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? ☐ 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 and herbals)

☐ I consent to ALL electronic prescriptions.

List ALL medications you take:

Name of Medication:	Dosage:

ALLERGIES (include food, contact, inhalant and drug)

☐ I have NO KNOWN drug allergies. ☐ Latex Allergy

Name of Medication:	Reaction:

SURGICAL HISTORY

☐ I have had NO operations/surgical procedures.

☐ PE Tubes
☐ Middle Ear Surgery
☐ External Ear Surgery
☐ Tonsillectomy
☐ Adenoidectomy
☐ Vocal Cord Surgery
☐ Septoplasty
☐ Turbinate Reduction
☐ Sinus Surgery
☐ Rhinoplasty
☐ Sleep Apnea
☐ Tympanoplasty

☐ Airway Surgery ☐ Parotid Surgery ☐ Mastoidectomy

☐ Thyroid Surgery ☐ Neck Surgery

☐ 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 ☐ Diabete ☐ Sickle Cell/Trait

☐ Blocked Arteries ☐ Thyroid Problem ☐ 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)/Roommate(s) ☐ With a Cat

☐ With Parents ☐ Assisted Living Facility ☐ Other: _____

☐ With Children ☐ Shelter _____

Have you ever or do you currently smoke or use tobacco products in any form? ☐ Yes ☐ No

☐ Cigarette _____Packs/Day ☐ E-Smoke Cigar ☐ Chewing

Quit? _____Years Smoked: _____ Packs/Day

Are you exposed to secondhand smoke? ☐ Yes ☐ No

Do you consume:

Alcoholic Beverages ☐ Yes ☐ No _____/Day _____/Week _____/Month

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