University Otolaryngology Associates, P.C

#_____
(Office use only)

Name_____ Date_____
Last, First, Middle Initial –*As it appears on your insurance card*

PATIENT DATA

Address:_____

_____

City : _____ State _____ Zip _____

Soc Sec No:_____

Birthdate:_____ Marital Status: _____

Sex: Male / Female (Circle one)

Telephone Numbers:

_____
[ ] Home [ ] Cell [ ] Work

_____
[ ] Home [ ] Cell [ ] Work

_____
[ ] Home [ ] Cell [ ] Work

Emergency Contact:_____
Name Phone

FAMILY PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____) _____

INSURANCE INFORMATION

Primary Insurance Carrier:_____

Subscriber's Name (If different than patient): _____ Relationship:_____

Sex: Male / Female (Circle one) Birthdate:_____ S.S.# _____

ID/Plan #: _____ Group#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____) _____

Secondary Insurance Carrier:_____

Subscriber's Name: _____ Relationship:_____

Sex: Male / Female (Circle one) Birthdate:_____ S.S.# _____

ID/Plan #: _____ Group#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____) _____

Medicare Secondary – please give reason:

□ Patient/Spouse working (12) □ Disability (43) □ Other – please specifiy:_____

OTHER INSURANCE (Circle one) Motor Vehicle Worker's Comp.

Date of Accident: _____MV/WC Company:_____

Adjuster' Name:_____Phone #: (____) _____

Address: _____

VERY IMPORTANT Claim #:_____Policy #_____

Policy Holder' s Name (if other than patient)_____

Name: **DOB:** **#**

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PATIENT'S PAYMENT RESPONSIBILITY:
I, the guarantor understand that I am fully responsible for all fees payable to University Otolaryngology Associates, P.C., and / or any associate rendering medical treatment to me or the patient for whom I am financially responsible.

LEGAL, MOTOR, VEHICLE, OR WORKERS' COMPENSATION CASES:
I understand that if I am involved in any of these types of cases, I must present all relevant documentation before any service with the physician. I must also present my personal health insurance coverage, for coverage if my accident – related coverage, expires, or terminates. If the appropriate information is not presented at the time of service, all balances will become my responsibility.

CLAIMS SUBMISSIONS:
Depending on my insurance carrier, the doctors' office may file directly to the insurance company for services rendered in the office. Claim submission policies for participating and non-participating insurances are located in the billing office for review. I am aware of the relevant insurance companies with which the doctors participate and I am fully aware it the physician I am to see is a participating or non-participating in the medical insurance plan that I am covered under. By signing this agreement, I acknowledge that I am fully aware of my co-pays, deductibles, and non-covered services. I am also aware that my co-pay is due before I leave the office at each visit. I acknowledge that the doctor's office will bill me for balances due and that I am fully responsible for all balances billed.

REFERRAL:
I understand that it is my responsibility to bring a referral authorization with me at the time of each service date, if my insurance company requires such an authorization. If the referral is not presented prior to services being rendered, I acknowledge that I will sign a financial release form, holding the guarantor personally responsible, for any services that are not covered by my insurance carrier for that visit date.

PAYMENT PLANS AND COLLECTION:
I acknowledge that the doctor's office can submit any unpaid balance due over 121 days to a collection agency. I also acknowledge that if I am unable to pay the entire balance, I may arrange to make monthly payments with the billing office. If I am not consistent with my monthly payments, my full balance may be placed with the doctors' collection agency after one notice.

PRIVACY PRACTICES:
I hereby acknowledge that I have received a copy of University Otolaryngology Associates, Inc.'s Notice of Privacy Practices.
Name of Personal Representative, if applicable:_____

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL AND FINANCIAL INFORMATION:
The signature below will authorize University Otolaryngology Associates, P.C., and / or any associate of the practice to furnish or receive from physician(s) / attorney(s) / insurance company _____ any information and / or opinions which they require, or to photocopy the same.

I request that payment of authorized Medicare / insurance benefits be made either to me or on my behalf to University Otolaryngology Associates, P.C., for any services furnished to me by the practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Patient's Signature Date

_____

Guarantor's Signature Date

MEDICAL INFORMATION FORM

NAME: _____ DOB: _____ # _____
(Office use only)

DATE: _____ REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY

- ☐ Heart Disease
- ☐ Heart Attack Date: _____
- ☐ Heart Surgery Date: _____
- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Poor Circulation
- ☐ Respiratory Disease
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Sarcoidosis
- ☐ Ulcer
- ☐ Reflux
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Stroke Date: _____
- ☐ Parkinson's Disease
- ☐ Tremor
- ☐ Weakness
- ☐ Psychiatric Illness
- ☐ Depression
- ☐ Vision Problems
  - ☐ Cataract
  - ☐ Macular Degeneration
  - ☐ Glaucoma
- ☐ Diabetes
  - ☐ Insulin
- ☐ Thyroid Disease
- ☐ Thyroid Surgery Date: _____
- ☐ Renal Failure
  - ☐ Dialysis Date Began: _____
- ☐ HIV
- ☐ Cancer
  - ☐ Lung
  - ☐ Breast
  - ☐ Lymphoma
  - ☐ Leukemia
  - ☐ Bone
- ☐ Allergies
  - ☐ Hay Fever
  - ☐ Foods
- ☐ Skin Disease
  - ☐ Psoriasis
  - ☐ Dermatitis
  - ☐ Hives

SOCIAL HISTORY

☐ Alcohol ☐ Beer ☐ Tobacco

SURGERY

- ☐ Tonsillectomy
- ☐ Stapedectomy
- ☐ Mastoidectomy
- ☐ Nasal/Sinus
- ☐ Brain
- ☐ Breast
- ☐ Back
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Carpal Tunnel
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Joint Scope
- ☐ Other _____

SYMPTOMS

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Ear Pressure
- ☐ Dizziness
- ☐ Nasal Pain
- ☐ Congestion
- ☐ Nasal Drainage
- ☐ Sneezing
- ☐ Facial Pain
- ☐ Sinus Pressure
- ☐ Headache
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hoarseness
- ☐ Dry Mouth
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Neck Pain
- ☐ Arm/Leg Pain
- ☐ Arm/Leg Weakness
- ☐ Slurred Speech
- ☐ Facial Weakness
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chest Pain
- ☐ Wheeze
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Nausea
- ☐ Vomiting
- ☐ Sleep Trouble
- ☐ Snoring

DRUG ALLERGIES

☐ Penicillin (Keflex, Amoxicillin) ☐ Erythromycin ☐ Sulfa ☐ Other _____ ☐ No Known Drug Allergies

Other problems or information we should know: _____

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Due to newly enacted FEDERAL MANDATES, we are now required to obtain some additional information from you. Please complete the following items as best possible:

Patient's Name _____ Date _____

Date of Birth _____

Pharmacy Name and Phone Number _____

Name of Mail Order Pharmacy _____

Reason for visit _____

Specific instructions: the two questions below are designed to identify you ethnicity and race. Regardless of your answer to question 1, go to question 2.

Question 1. Are you Hispanic/Latino (choose only one)
_____ No, not Hispanic/Latino?
_____ Yes, Hispanic/Latino (A person who is Cuban, Mexican. Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race).

Question 2. Please select the racial category or categories with which you most closely identify.
_____American Indian or Alaskan Native _____Asian _____Black or African American

_____Native Hawaiian or Other Pacific Islander _____ Caucasian

Language of choice _____

Tobacco use: Never _____ Currently using _____ Formerly used tobacco _____

Height _____feet _____ inches Weight _____ lbs

Have you ever received a Pneumovax (pneumonia) vaccine? Yes _____ No _____ Unsure _____

Have you had a flu shot this flu season (since September 1)? Yes _____ No _____ Unsure _____

Women over 40; have you ever had a mammogram? Yes _____ No _____ Unsure _____

We are required to update your health information at each and every visit. Please bring with you to each visit c current list of all medications (including dosage and frequency) as well as a list of any new medical problems or allergies.

Please list current medications:

_____

_____

_____

_____

_____

Allergies to medication:

_____

_____

_____

_____

_____