ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

Salutation/Titular: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name:

_____ Date of

Birth:_____ Age:_____

Sex: F____ M ____ Marital Status: M ___ S___ D ___ W___ Other___

Please check appropriate response:

*** *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____ Native**

Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

****Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____**

Religion: _____ Primary Language: _____ Maiden Name:

_____ Responsible Party/Guarantor

Name:_____

Patient's

Address:_____ Street

City, State Zip Patient's 2nd Address:_____ _____Full-time

_____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell)

(_____)_____ Please check your preference on how to contact you: Home Phone:___ Cell Phone:

___ Other: _____ Email

Address:_____ Employer Name:_____

Emergency

Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring

you?_____ Referring

Physician:_____ Primary Care Physician:_____ Is

this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy

Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ **Subscriber's Name:**_____

_____ **Relationship to Patient:**_____**Date of**

Birth:_____**ID#**_____**Group#**_____ **Secondary Insurance**

Company:_____ **Subscriber's Name:**_____ **Relationship to**

Patient:_____ **Date of Birth**:_____**ID#**_____**Group#**_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____**Date**:_____

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Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

No Known Drug Allergies

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: □ Yes □ No Patient/Guardian Signature: _____**

Print Patient Name: _____ D.O.B:_____

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MEDICAL HISTORY FORM

Patient Name: Date of Birth: M or F

Referring Physician: _____ *Pharmacy Name

_____ *Pharmacy Cross Street_____

*Pharmacy Phone Number_____

Primary Care Physician:_____ **Weight:** _____ **Height**:

_____ **Briefly,** why are you seeing our physician today?

1. Patient History - Please check your response

Yes No

Cancer (enter details below) ( ) ( ) Heart (enter details below) ( ) ( ) Cardio: Hypertension ( ) ( ) Ear: Dizziness ( ) ( )
Ear: Hearing Loss ( ) ( ) Ear: Tinnitus/Ringing in Ear ( ) ( ) Endocrine: Diabetes ( ) ( ) Endocrine: Thyroid Disorders ( ) ( ) G.I.: Bowel Disorders ( ) ( ) G.I.: Liver Disorders ( ) ( ) G.I.: Stomach Disorders/Ulcers ( ) ( )
G.I.: Reflux/GERD/Heartburn ( ) ( ) Immuno: HIV ( ) ( ) Immuno: Immune Dieases ( ) ( ) Lymph: Anemia ( ) ( ) Lymph: Bleeding Disorders ( ) ( )

surgeries/hospitalizations:

Yes No

Nasal: Allergies ( ) ( ) Nasal: Nasal Trauma ( ) ( )
Nasal: Nose Bleeds ( ) ( ) Nasal: Sinusitis ( ) ( )
Neuro: Headaches/Migraines ( ) ( ) Neuro: Nervous System ( ) ( ) Neuro: Seizure Disorder ( ) ( ) Ophth: Eyes/Glaucoma ( ) ( ) Oral: Sleep Apnea ( ) ( ) Pysch:PsychiatricDisorders ( ) ( )
Pulm: Lungs ( ) ( ) Pulm: Tuberculosis ( ) ( )
Uro:Bladder Disorders ( ) ( ) Uro: Kidney ( ) ( )

Other:

Details of Yes answers:

2. Surgeries - Please list any

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3. Social History - Are you a current smoker? (Y or N) You now smoke packs of cigarettes a day. You smoked packs per day and quit years ago.

You consume alcoholic beverages per day / week / month (circle).

How many caffeinated beverages do you drink per day? _____

4. Family History - Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Cancer	( )	( )
Diabetes	( )	( )	Headaches/Migraine	( )	( )
Immune Disease	( )	( )	Premature Hearing Loss	( )	( )
Sinusitis	( )	( )	Sleep Apnea	( )	( )
Thyroid Disorders	( )	( )			

Details of Yes answers:

Patient Signature: Date:

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(Print Patient Name) **Financial Consent** **D.O.B: _____** I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional administration fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

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_____
Patient Initials

PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain

formularies which are lists of dispensable drugs covered by a particular benefit plan. **Appointment Reminders**

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(Print Patient Name) D.O.B: _____

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. Based on the information being communicated, there may be a potential of multiple texts in order to provide necessary information. I acknowledge and consent to receive text messages from the practice to my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing or choose to opt out.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent
- Appointment Reminders

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/ Guardian Signature:_____ Date:_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary

carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/ Guardian Signature:_____ Date:_____