

DATE: \_\_\_\_\_ DOCTOR \_\_\_\_\_  
TIME \_\_\_\_\_

ADULT INFORMATION SHEET

FULL NAME \_\_\_\_\_

NICKNAME: \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

MAILING ADDRESS: STREET \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

\_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ SEPARATED \_\_\_\_\_ DIVORCED

SPOUSE'S FULL NAME: \_\_\_\_\_

LAST FIRST MI

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

SPOUSE'S PLACE OF EMPLOYMENT \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

HOW WOULD YOU LIKE TO BE NOTIFIED FOR APPOINTMENT CONFIRMATION?

EMAIL  PHONE

\*\*\*\*\*

\*\* HOW DID YOU HEAR ABOUT OUR CLINIC? \_\_\_\_\_

\*\* WHO IS RESPONSIBLE FOR THIS BILL? \_\_\_\_\_

\*\* WHICH PHYSICIAN REQUESTED THIS CONSULTATION? \_\_\_\_\_ CITY/STATE \_\_\_\_\_

\*\* FAMILY DOCTOR? \_\_\_\_\_ CITY/STATE \_\_\_\_\_

\*\* WHO CAN WE CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

\*\* I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM FILED OR RELEASE MEDICAL RECORDS ON MY BEHALF.

\*\* I ALSO ASSIGN ANY BENEFITS FROM MY INSURANCE COMPANY LISTED ABOVE TO THE PHYSICIAN FOR SERVICES DESCRIBED ON THE CLAIM FORM.

FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Review of Systems

Please Check Those That Apply

Constitutional	Respiratory	Cardiovascular	Neurologic
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Known TB exposure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mental disturbance
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Cough	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Headache
<input type="checkbox"/> Chills	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Swelling of extremities	<input type="checkbox"/> Clumsiness
<input type="checkbox"/> Decreased Activity	<input type="checkbox"/> Spitting/coughing up blood	<input type="checkbox"/> Shortness of breath at night	<input type="checkbox"/> Changes in speech
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Irregular heartbeat/palpitations	
<input type="checkbox"/> Fever	<input type="checkbox"/> Snoring		
<input type="checkbox"/> Insomnia			
<input type="checkbox"/> Irritability			
<input type="checkbox"/> Night Sweats			
<input type="checkbox"/> Weight gain			

### HEENT

<input type="checkbox"/> Headaches			
Eyes	Ears	Nose/Sinus	Throat/Mouth
<input type="checkbox"/> Burning eyes	<input type="checkbox"/> Discharge from ears	<input type="checkbox"/> Unusual sense of smell	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Double vision	<input type="checkbox"/> Excess Wax in ears	<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Change in taste
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Fullness of ears	<input type="checkbox"/> Nosebleed	<input type="checkbox"/> Sore tongue
<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Voice change
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Congestion	<input type="checkbox"/> Lump in throat
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Nasal blockage	<input type="checkbox"/> Problems swallowing
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Ringing of ears	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Post Nasal drip
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Floaters			<input type="checkbox"/> Tooth pain
<input type="checkbox"/> Abnormal field of vision			
<input type="checkbox"/> Visual Loss			

Gastrointestinal	Immunological	Metabolic/Endocrine	Genitourinary
<input type="checkbox"/> Nausea	<input type="checkbox"/> Previous allergy testing	<input type="checkbox"/> Excessive fatigue	<input type="checkbox"/> Cloudy Urine
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Previous allergy shots	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Bloating	<input type="checkbox"/> Animals in the home	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Decreased urine output
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Constipation	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Increased urination	
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Overweight	
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hives	<input type="checkbox"/> Underweight	
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Asthma	<input type="checkbox"/> Abnormal sleep pattern	
		<input type="checkbox"/> Hair loss	

Musculoskeletal	Hematologic	Dermatologic	Vascular
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Acne	<input type="checkbox"/> Cool extremities
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Rash	<input type="checkbox"/> Swelling of extremities
<input type="checkbox"/> Bone/joint pain	<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Itching	
	<input type="checkbox"/> History of blood clots	<input type="checkbox"/> Abnormal mole/lesion	

Patient Signature/Date \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Name & Location of Pharmacy:** \_\_\_\_\_

**List of Current Medications & Dosages:** (use back if necessary)

- None
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_  
9. \_\_\_\_\_ 10. \_\_\_\_\_ 11. \_\_\_\_\_ 12. \_\_\_\_\_

**List of Medication Allergies:** (use back if necessary)

- None
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Date of Your Last Flu Shot** \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_ Pets in the home: \_\_\_\_\_

Tobacco Use: Yes No Type _____	Alcohol Use: Yes No _____	Daily Weekly Occasional
Amount Used per Day _____	Type of Alcohol Used _____	
Ever Quit? _____ How Long Quit? _____	Amount Used _____	
# Years Used _____		

**Past Medical History: Please fill out completely (use back if necessary)**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Kidney Problems   | <input type="checkbox"/> Psychotic Disorder | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Depression         | <input type="checkbox"/> Sleep Apnea        |
| <input type="checkbox"/> Heart Failure    | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Ear Infections     |
| <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Throat Infections  |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> HIV               | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Chronic Sinusitis  |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis _____   | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Hearing Loss       |
| <input type="checkbox"/> Skin Rash        | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Cancer _____       | <input type="checkbox"/> Vocal Cord Nodules |
| <input type="checkbox"/> Acid Reflux      | <input type="checkbox"/> Lupus             | _____                                       | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Stomach Ulcer    | <input type="checkbox"/> Fibromyalgia      |   | <input type="checkbox"/> Ringing Ears       |

**Past Surgical History: (Please list ALL past surgeries with approximate dates)**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_  
9. \_\_\_\_\_ 10. \_\_\_\_\_ 11. \_\_\_\_\_ 12. \_\_\_\_\_

**Family History (please indicate which family member is affected)**

(mother, father, maternal or paternal grandparents, sister, brother child)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies _____         | <input type="checkbox"/> Diabetes _____               | <input type="checkbox"/> Kidney Disease _____   |
| <input type="checkbox"/> Asthma _____            | <input type="checkbox"/> Childhood Hearing loss _____ | <input type="checkbox"/> Seizures _____         |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Cancer _____                 | <input type="checkbox"/> Sickle Cell _____      |
| <input type="checkbox"/> Heart Disease _____     | <input type="checkbox"/> Migraines _____              | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Stroke _____            | <input type="checkbox"/> Otosclerosis _____           | <input type="checkbox"/> Other _____            |

Parents Deceased?  Cause of Death \_\_\_\_\_



## Ear, Nose and Throat Physicians, P.A.

### Consent for Treatment

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

#### **CHILDREN** (FAMILY MEMBERS ONLY)

PLEASE LIST ALL PERSONS THAT MAY BRING YOUR CHILD TO OUR CLINIC AND THAT WE MAY TALK TO REGARDING YOUR CHILD'S CARE AND TREATMENT:

(EXAMPLE: GRANDPARENTS, AUNTS/UNCLES, ETC.)

_____	_____
_____	_____
_____	_____

ONLY PARENTS OR LEGAL GUARDIANS MAY SIGN CONSENTS FOR SURGERY OR GET COPIES OF MEDICAL RECORDS.

#### **ADULTS** (FAMILY MEMBERS ONLY)

PLEASE LIST ALL PERSONS WHO MAY HAVE ACCESS TO YOUR MEDICAL RECORD:

_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

\_\_\_\_\_  
DATE

PATIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING:

**ASSIGNMENT OF INSURANCE AND/OR MEDICARE BENEFITS**

I request that payment of authorized Medicare benefits or any insurance payments be made on my behalf to EAR, NOSE & THROAT PHYSICIANS OF NORTH MISS., P.A. or my treating physician for any services rendered to me by that Physician. I authorize any holder of my protected health information to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or any related claims. I assign the benefits payable for physician services to the physician. This authorization is valid for lifetime.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize this clinic or my treating physician to release a copy of any and all protected health information they possess relative to my treatment to my insurance company or other agencies for the purpose of substantiating payment for this claim. I further authorize the release of my protected health information concerning my illness and/or treatment to other physicians or facilities that are involved in my care, as well as obtaining prescribed medications from other outside sources.

**NON-CERTIFICATION OF PRE-CERTIFICATION, ADMISSION OR REQUIRED SECOND OPINION**

I hereby agree that as the policyholder or patient I have the responsibility of assuring certification is obtained from my insurance company or employer for service rendered. If certification or a second opinion is not obtained, I further agree that in the event the insurance company denies either all or part of their payment on the physician charges, I will pay the account in full upon demand from EAR, NOSE & THROAT PHYSICIANS OF NORTH MISS., P.A.

**FINANCIAL REPONSIBILITY AGREEMENT**

I understand that I am financially responsible for all charges not covered by or paid by my insurance company. If I do not have insurance, I take full responsibility for the payment of all charges.

**DIVORCED PARENTS**

Our office policy regarding a child of divorced parents is as follows. The parent who brings the child to the office or hospital for care by our physicians is the parent responsible for the doctor's fee. Any arrangement that must be made between the two parents concerning the payment is the responsibility of the parents, not our office.

**CONSENT FOR TREATMENT**

I give authority to EAR, NOSE & THROAT PHYSICIANS OF NORTH MISS., P.A. or my treating physicians to provide medical services as necessary to me, or to a minor for whom I am responsible.

\*A copy of this authorization is as valid as the original.

I acknowledge that I have been given and received a copy of Ear, Nose, & Throat Physicians of North Miss., P.A. Notice of Privacy Practices.

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Signature of Patient or Authorized Person

DATE



## PRIVACY NOTICE

Your Privacy Is Important

Ear, Nose and Throat Physicians of North MS, P.A., understands your privacy is important. You have received this notice in accordance with applicable state and federal laws and because you are a current or potential patient. This notice will help you understand what types of nonpublic personal information- information about you that is not publicly available – we may collect, how we use it and how we protect your privacy. This is a summary of our Privacy Practices- if you would like more information, please inquire with the doctor or the receptionist.

### **Ear, Nose and Throat Physicians of North MS Privacy policy highlights:**

- ◆ We collect nonpublic personal information to process and administer our patients' business.
- ◆ We have policies and procedures in place to protect nonpublic personal information about our patients or their families.
- ◆ We do not sell nonpublic personal information about our patients or their families to 3<sup>rd</sup> parties, i.e., companies or individuals that are not affiliated with us.
- ◆ We do not disclose any nonpublic personal information about our patients or their families to anyone, except as permitted by law.
- ◆ We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment and healthcare operations.
- ◆ For all other purposes, we will either obtain your authorization or remove all information that could identify you as an individual.
- ◆ Our Privacy Policy applies to both current and former patients.

### **QUESTIONS AND ANSWERS that detail Ear, Nose and Throat Physicians of North MS, P.A. Privacy Policy**

#### **What type of nonpublic personal information does Ear, Nose and Throat Physicians collect?**

ENT employees, representatives, agents and selected third parties may collect nonpublic personal information about our patients or their families, including:

- ◆ Information provided to us, such as on applications or other forms
- ◆ Information about transactions with affiliates, our third parties or us.
- ◆ Information from others; such as credit reporting agencies, employers and federal and state agencies.

The types of nonpublic personal information Ear, Nose and Throat information collects vary according to the products or services provided and may include, for example: account balances, insurance premiums, marital status and health history.

#### **What does Ear, Nose and Throat Physicians do to protect nonpublic personal information?**

We restrict access to nonpublic personal information to those employees, agents, representatives or third parties who need to know the information to provide products and services to our patients or their families.

We have policies and procedures that give direction to our employees, and agents and representatives acting on our behalf, regarding how to protect and use nonpublic personal information.

We maintain physical, electronic, and procedural safeguards to protect nonpublic personal information.

#### **With whom does Ear, Nose and Throat Physicians share nonpublic personal information, and why?**

We do not share nonpublic personal information about our patient or their families with anyone, including other affiliated companies or third parties, except as permitted by law.

We may disclose, as allowed by law, all types of nonpublic personal information we collect when needed to, to affiliated companies, agents, employees, representatives and third parties that market our services and products and administer and service customer accounts on our behalf. Examples of the types of companies and individuals to whom we may disclose nonpublic personal information include attorneys, trustees, third party administrators, insurance agents, insurance companies, insurance support organizations, credit reporting agencies, registered broker/dealers, auditors and regulators.

We do not share personally identifiable health information unless the customer or the applicable law authorizes further sharing.

#### **Does Ear, Nose and Throat Physicians policy apply to its agents and representatives?**

ENT privacy policy applies, to the extent required by law, to its agents and representatives when they are acting on behalf of Ear, Nose and Throat Physicians of North MS

Please Note: There may be instances when these same agents and representatives may not be acting on behalf of Ear, Nose and Throat Physicians, in which case they may collect nonpublic personal information on their own behalf or on behalf of another. In the instances, Ear Nose and Throat's Privacy Policy would not apply.

#### **Will Ear, Nose and Throat Physicians Privacy Policy Change?**

Ear, Nose and Throat Physicians of North MS reserves the right to change any of its privacy policies and related procedures at any time, in accordance with applicable federal and state laws. You will receive appropriate notice if our Privacy Policy changes.

This privacy notice is provided to you for informational purposes only. You do not need to call or take any action in response to this notice. We recommend that you read and retain this notice for your personal files.