DATE: ______________________________ DOCTOR ______________________________

TIME ______________________________

CHILD INFORMATION SHEET

CHILD INFORMATION

NAME (Last, First, Middle)			SSN #	BIRTHDATE	AGE	SEX
LOCAL ADDRESS		CITY, STATE, ZIP	SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS ❑ Full-time ❑ Part-time		HOME PHONE			

HOW DID YOU HEAR ABOUT OUR CLINIC? ______________________________

FATHER'S FULL NAME ______________________________
LAST FIRST MI

MAILING ADDRESS: STREET ______________________________

CITY ______________________________ STATE __________ ZIP CODE __________

PLACE OF EMPLOYMENT ______________________________ EMAIL ADDRESS ______________________________

HOME PHONE # ____________________ WORK PHONE # ____________________ CELL PHONE # ____________________

BIRTHDATE ______________________________ SOCIAL SECURITY # ______________________________

MOTHER'S FULL NAME ______________________________
LAST FIRST MI

MAILING ADDRESS: STREET ______________________________

CITY ______________________________ STATE __________ ZIP CODE __________

PLACE OF EMPLOYMENT ______________________________ EMAIL ADDRESS ______________________________

HOME PHONE # ____________________ WORK PHONE # ____________________ CELL PHONE # ____________________

BIRTHDATE ______________________________ SOCIAL SECURITY # ______________________________

* *

HOW WOULD YOU LIKE TO BE NOTIFIED FOR APPOINTMENT CONFIRMATION? ❑ EMAIL ❑ PHONE

**WHO IS RESPONSIBLE FOR THIS BILL? ______________________________

**WHO IS ACCOMPANYING THIS PATIENT TODAY? CIRCLE ONE OF THE FOLLOWING:

FATHER, MOTHER, LEGAL GUARDIAN, OTHER (WHAT RELATIONSHIP) ______________________________

**REQUESTING DOCTOR ______________________________ 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
- ❑ Weight Loss
- ❑ Change in appetite
- ❑ Chills
- ❑ Decreased Activity
- ❑ Fatigue
- ❑ Fever
- ❑ Insomnia
- ❑ Irritability
- ❑ Night Sweats
- ❑ Weight gain

Respiratory
- ❑ Known TB exposure
- ❑ Cough
- ❑ Shortness of breath
- ❑ Spitting/coughing up blood
- ❑ Wheezing
- ❑ Snoring

Cardiovascular
- ❑ Fainting
- ❑ Chest pain
- ❑ Swelling of extremities
- ❑ Shortness of breath at night
- ❑ Irregular heartbeat/palpitations

Neurologic
- ❑ Mental disturbance
- ❑ Headache
- ❑ Clumsiness
- ❑ Changes in speech

HEENT
- ❑ Headaches

Eyes
- ❑ Burning eyes
- ❑ Double vision
- ❑ Dry eyes
- ❑ Watery eyes
- ❑ Itchy eyes
- ❑ Eye pain
- ❑ Light sensitivity
- ❑ Red eyes
- ❑ Floaters
- ❑ Abnormal field of vision
- ❑ Visual Loss

Ears
- ❑ Discharge from ears
- ❑ Excess Wax in ears
- ❑ Fullness of ears
- ❑ Hearing loss
- ❑ Ear infections
- ❑ Ear pain
- ❑ Ringing of ears
- ❑ Dizziness

Nose/Sinus
- ❑ Unusual sense of smell
- ❑ Nasal discharge
- ❑ Nosebleed
- ❑ Facial pain
- ❑ Congestion
- ❑ Nasal blockage
- ❑ Sneezing
- ❑ Sinusitis

Throat/Mouth
- ❑ Tonsillitis
- ❑ Change in taste
- ❑ Sore tongue
- ❑ Voice change
- ❑ Lump in throat
- ❑ Problems swallowing
- ❑ Post Nasal drip
- ❑ Sore throat
- ❑ Tooth pain

Gastrointestinal
- ❑ Nausea
- ❑ Abdominal pain
- ❑ Bloating
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Constipation
- ❑ Acid Reflux
- ❑ Vomiting
- ❑ Jaundice

Immunological
- ❑ Previous allergy testing
- ❑ Previous allergy shots
- ❑ Animals in the home
- ❑ Food Allergies
- ❑ Environmental Allergies
- ❑ Dermatitis
- ❑ Hay Fever
- ❑ Hives
- ❑ Asthma

Metabolic/Endocrine
- ❑ Excessive fatigue
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Increased appetite
- ❑ Increased thirst
- ❑ Increased urination
- ❑ Overweight
- ❑ Underweight
- ❑ Abnormal sleep pattern
- ❑ Hair loss

Genitourinary
- ❑ Cloudy Urine
- ❑ Painful urination
- ❑ Decreased urine output
- ❑ Frequent Urination
- ❑ Blood in urine

Musculoskeletal
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Bone/joint pain

Hematologic
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Enlarged lymph nodes
- ❑ History of blood clots

Dermatologic
- ❑ Acne
- ❑ Rash
- ❑ Itching
- ❑ Abnormal mole/lesion

Vascular
- ❑ Cool extremities
- ❑ Swelling of extremities

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 _____
Amount Used per Day _____
Ever Quit?_____ How Long Quit? _____
Years Used _____

Alcohol Use: Yes No Daily Weekly Occasional
Type of Alcohol Used _____
Amount Used _____

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

❑ Heart Disease
❑ Stroke
❑ Heart Failure
❑ Coronary Disease
❑ Hypertension
❑ High Cholesterol
❑ Skin Rash
❑ Acid Reflux
❑ Stomach Ulcer
❑ Kidney Problems
❑ Anemia
❑ Bleeding Disorder
❑ Allergies
❑ HIV
❑ Hepatitis ____
❑ Diabetes
❑ Lupus
❑ Fibromyalgia
❑ Psychotic Disorder
❑ Depression
❑ Seizures
❑ Migraines
❑ Emphysema
❑ Asthma
❑ Cancer _____
_____
❑ Thyroid Problems
❑ Sleep Apnea
❑ Ear Infections
❑ Throat Infections
❑ Chronic Sinusitis
❑ Hearing Loss
❑ Vocal Cord Nodules
❑ Dizziness
❑ 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)

❑ Allergies _____
❑ Asthma _____
❑ Bleeding Disorder _____
❑ Heart Disease _____
❑ Stroke _____
❑ Diabetes _____
❑ Childhood Hearing loss _____
❑ Cancer _____
❑ Migraines _____
❑ Otosclerosis _____
❑ Kidney Disease _____
❑ Seizures _____
❑ Sickle Cell _____
❑ Thyroid Disorder _____
❑ 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.

_____

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 3rd 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.