

**PATIENT INFORMATION**

PATIENT'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PHONE: HOME # \_\_\_\_\_ CELL # \_\_\_\_\_ WORK # \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M  F  LANGUAGE: ENGLISH  OTHER: \_\_\_\_\_

MARITAL STATUS: Married  Single  Widowed  Divorced

RACE: AFRICAN AMERICAN  CAUCASIAN/WHITE  OTHER \_\_\_\_\_ DECLINED

EMAIL \_\_\_\_\_ PREFERRED PHARMACY \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

INDIVIDUAL RESPONSIBLE FOR THIS ACCOUNT SAME AS ABOVE

NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

PHONE: HOME # \_\_\_\_\_ CELL # \_\_\_\_\_ WORK # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_

GROUP # \_\_\_\_\_ CARD HOLDER \_\_\_\_\_ DOB \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_

GROUP # \_\_\_\_\_ CARD HOLDER \_\_\_\_\_ DOB \_\_\_\_\_

EMERGENCY CONTACT #1 \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_

EMERGENCY CONTACT #2 \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_

EMERGENCY CONTACT #3 \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_

## CONSENT FOR TREATMENT OF A MINOR

A minor is anyone 17 years of age or younger.

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Thank you for entrusting the care of your child to Central-Missouri Ear, Nose, Throat, Sinus & Allergy. To provide the best quality of care for your child we require that a parent or legal guardian accompany the child to appointments. We realize that your child may need to be seen for an acute sick visit and a parent or legal guardian may be unable to be present. By completing the information below we will be able to meet the needs of your child during your absence.

In the absence of a parent or legal guardian, I give the person(s) listed below permission to seek medical care and treatment for my child. I also realize that the person below may have access to pertinent protected health information if medically necessary. These individuals will be asked to present identification at the time of the visit. If someone other than these persons listed below brings in your child, we will attempt to contact a parent or legal guardian for verbal permission to treat.

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please be sure the person accompanying your child has all the pertinent information regarding your child's illness in order to provide the highest quality of care.

\_\_\_\_\_  
Signature Relationship Date

Parent(s) or Legal Guardian(s) contact information:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Number: _____	Home Number: _____
Cell Number: _____	Cell Number: _____
Work Number: _____	Work Number: _____

## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by the office of Central Missouri Ear, Nose, Throat, Sinus & Allergy, P.C. that the Notice of Privacy Practices is available in the waiting room for my review.

By signing below, I acknowledge that I have been provided with an opportunity to read Central Missouri Ear, Nose, Throat, Sinus & Allergy, P.C.'s Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed. I further understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party providers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that information will not be discussed with any other person(s) unless authorized below. I hereby authorize the following individual(s) to receive information regarding my medical condition:

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Removal or changes of one or more names listed above may be made in writing by the patient, parent, or legal guardian if the patient is unable to sign for himself/herself.

## FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and regard your understanding of your financial responsibilities an essential element of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

- **APPOINTMENTS** – We request 24 hours notice in the event you cannot keep an appointment, otherwise a cancellation fee of \$25 may be added to your account.
- **INSURANCE** – You are responsible for knowing your insurance policy. We will submit your claim to your insurance carrier. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier including services not covered by your insurance plan. If additional tests are required as part of your treatment, you will be billed separately for those services by the providing facility, anesthesiologist, laboratory and/or radiologist.

Please remember that your insurance policy is a contract between you and your insurance company. While we will assist you by filing your claims, you will be responsible for any balance your plan indicates as due on their explanation of benefits form.

### **Lifetime Private Insurance Authorization of Benefits / Release of Information:**

I, the undersigned, authorize and direct my health insurance company, or self-insured plan, to make payment of medical benefits to Central Missouri Ear, Nose, Throat, Sinus & Allergy, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the sole purpose of evaluating and administrating claims of benefits.

- **REFERRALS** – Referrals are the patient's responsibility. You are responsible for any charges incurred if your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services and you have not obtained such authorization or referral; or if you receive services in excess of such authorization or referral. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider prior to your appointment to find out if this is applicable.
- **CO-PAYMENTS** – By law we must collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **SELF-PAYMENTS** – Payment is expected at the time of service unless other arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance which will be filed to the secondary insurance if you have one.

### **Medicare Lifetime Signature on file:**

I request that payment of authorized Medicare benefits be made on my behalf to Central Missouri Ear, Nose, Throat, Sinus & Allergy, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to CMS (and its agents) any information needed to determine the benefits payable for related services. This information will be used for the sole purpose of evaluating and administering claims benefits.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the named Medigap insurer any information needed to determine benefits payable.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who signs the consent to treatment of a minor child is responsible for payment of services rendered. Central Missouri Ear, Nose, Throat, Sinus & Allergy, P.C. will not be involved with separation or divorce disputes.
- **FAMILY MEDICAL LEAVE ACT** – FMLA paperwork can be completed by our providers for a \$35 fee per application.

You are responsible for the timely payment of your account. Payment of any account balance is due within thirty (30) days of receipt of your billing statement. If you need to make special arrangements for payment, you may contact our billing department to determine a mutually agreeable payment plan.

We accept payment by CASH, CHECK, MONEY ORDER, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us any comments.

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# Patient History Form

**Patient Name:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

**Medical History**

List your present medications (include over the counter, vitamins and herbal supplements).

Medication	Dosage/Frequency	Medication	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on blood thinner, ibuprofen, or a daily aspirin? Yes \_\_\_\_\_ No \_\_\_\_\_

List all past/present medical illnesses

1 _____	4 _____
2 _____	5 _____
3 _____	6 _____

List previous surgeries/hospitalizations

Surgery/Hospitalization	Approximate Date	Surgery/Hospitalization	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medication allergies

Any allergy to Lidocaine or latex? Yes \_\_\_\_\_ No \_\_\_\_\_

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Do You?**

Yes \_\_\_\_\_ No \_\_\_\_\_  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 Yes \_\_\_\_\_ No \_\_\_\_\_

Smoke? If yes, how many packs per day? \_\_\_\_\_  
 Drink? If yes, circle one: Wine Beer Whiskey  
 Chew?  
 Are you a previous smoker? If yes, when did you quit? \_\_\_\_\_  
 Do you have a history of alcohol or substance abuse?

<b>Family History</b>	No History	Un Known	Mother	Father	Grand Mother	Grand Father	Siblings	Aunts or Uncles
Diabetes								
Cancer								
Heart Disease								
High Blood Pressure								
Asthma								
History of Bleeding								
Hearing problems								
Allergy/Sinus Problems								
Other:								
Other:								
Other:								
Other:								

## Review of Systems

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Do you have any problems related to the following? Please circle Yes or No

<p><b>Ear:</b></p> <p>Decreased Hearing            Y   N</p> <p>Pain                            Y   N</p> <p>Fullness                      Y   N</p> <p>Infection                      Y   N</p> <p>Ringing                        Y   N</p> <p>Dizziness                      Y   N</p> <p>Hearing Aids                 Y   N</p> <p>Drainage/Bleeding            Y   N</p> <p>Other _____            Y   N</p> <p><b>Nose:</b></p> <p>Blockage/Breathing         Y   N</p> <p>Congestion                    Y   N</p> <p>Drainage                        Y   N</p> <p>Infection                        Y   N</p> <p>Trauma                         Y   N</p> <p>Sneezing                        Y   N</p> <p>Bleeding                        Y   N</p> <p>Loss of Smell                 Y   N</p> <p>Other _____            Y   N</p> <p><b>Throat:</b></p> <p>Lumps/Growth                Y   N</p> <p>Pain                              Y   N</p> <p>Swelling                        Y   N</p> <p>Dryness/Itching              Y   N</p> <p>Tonsillitis                      Y   N</p> <p>Hoarseness                    Y   N</p> <p>Voice Change/Loss            Y   N</p> <p>Frequent Clearing            Y   N</p> <p>Cough                            Y   N</p> <p>Other _____            Y   N</p> <p><b>Sinus:</b></p> <p>Eye/Facial Swelling         Y   N</p> <p>Change in Vision             Y   N</p> <p>Pain/Pressure                 Y   N</p> <p>Drainage                        Y   N</p> <p>Headaches                      Y   N</p> <p>Infection                        Y   N</p> <p>Congestion                    Y   N</p> <p>Polyps                          Y   N</p> <p>Other _____            Y   N</p>	<p><b>Mouth:</b></p> <p>Sores on Tongue             Y   N</p> <p>Gum Swelling                 Y   N</p> <p>Lumps/Growth                Y   N</p> <p>Bleeding                        Y   N</p> <p>Loss of Taste                 Y   N</p> <p>Pain                                Y   N</p> <p>Bad Breath                    Y   N</p> <p>Other _____            Y   N</p> <p><b>Eyes:</b></p> <p>Watery                          Y   N</p> <p>Drainage                        Y   N</p> <p>Itching                          Y   N</p> <p>Change in Vision             Y   N</p> <p>Redness                         Y   N</p> <p><b>Neurological:</b></p> <p>Tremors/Seizures            Y   N</p> <p>Dizzy Spells                    Y   N</p> <p>Numbness/Tingling            Y   N</p> <p>Headache                        Y   N</p> <p>Other _____            Y   N</p> <p><b>Endocrine:</b></p> <p>Diabetes                        Y   N</p> <p>Too Hot/Cold                 Y   N</p> <p>Tired/Sluggish                Y   N</p> <p>Hair Loss                        Y   N</p> <p>Weight Loss                    Y   N</p> <p>Weight Gain                    Y   N</p> <p>Muscle Pain                    Y   N</p> <p>Fatigue                          Y   N</p> <p>Constipation                  Y   N</p> <p>Other _____            Y   N</p> <p><b>Gastrointestinal:</b></p> <p>Abdominal Pain                Y   N</p> <p>Nausea/Vomiting              Y   N</p> <p>Indigestion/Heartburn        Y   N</p> <p>Night Time Cough             Y   N</p> <p>Trouble Swallowing            Y   N</p> <p>Other _____            Y   N</p>	<p><b>Skin:</b></p> <p>Skin Rash                      Y   N</p> <p>Hives                            Y   N</p> <p>Persistent Itch                Y   N</p> <p>Other _____            Y   N</p> <p><b>Musculoskeletal:</b></p> <p>Joint Pain                        Y   N</p> <p>Neck Pain/Back Pain         Y   N</p> <p>Muscle Weakness              Y   N</p> <p>Other _____            Y   N</p> <p><b>Respiratory:</b></p> <p>Wheezing                        Y   N</p> <p>Frequent Cough                Y   N</p> <p>Shortness of Breath          Y   N</p> <p>Other _____            Y   N</p> <p><b>Hematological/Lymphatic:</b></p> <p>Swollen Glands                Y   N</p> <p>Blood Clotting Problems     Y   N</p> <p>Other _____            Y   N</p> <p><b>Psychological/Emotional:</b></p> <p>Depression                      Y   N</p> <p>Anxiety                          Y   N</p> <p>Medication                      Y   N</p> <p>Other _____            Y   N</p> <p><b>Allergic/Immunological:</b></p> <p>Hay Fever                        Y   N</p> <p>Drug Allergies                 Y   N</p> <p>Food Allergies                 Y   N</p> <p>Other _____            Y   N</p> <p><b>General:</b></p> <p>Frequently Tired                Y   N</p> <p>Night Sweats                    Y   N</p> <p>AIDS                              Y   N</p> <p>Hepatitis                         Y   N</p> <p>Other _____            Y   N</p> <p><b>Cardiovascular:</b></p> <p>Chest Pain                        Y   N</p> <p>High Blood Pressure          Y   N</p> <p>Irregular Heart Rate         Y   N</p> <p>Other _____            Y   N</p>
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