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 your 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: ______________________________

Relationship:______________________________

Home Number: ________________________

Cell Number: __________________________

Work Number: _________________________

Name: ______________________________

Relationship:______________________________

Home Number: ________________________

Cell 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 allergies to medications Any allergy to Lidocaine or latex? Yes _____ No _____

Do You?

Yes _____	No _____	Smoke? If yes, how many packs per day? _____
Yes _____	No _____	Drink? If yes, circle one: Wine Beer Whiskey
Yes _____	No _____	Chew?
Yes _____	No _____	Are you a previous smoker? If yes, when did you quit?________
Yes _____	No _____	Do you have a history of alcohol or substance abuse?

Family History	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:** ____ / ____ / ____

Please circle Y to indicate which symptoms you have currently or have had in the last 12 months.

Ear:

Symptom		
Decreased Hearing	Y	N
Pain	Y	N
Fullness	Y	N
Infection	Y	N
Ringing	Y	N
Dizziness	Y	N
Hearing Aids	Y	N
Drainage/Bleeding	Y	N
Other ______________	Y	N

Nose:

Symptom		
Blockage/Breathing	Y	N
Congestion	Y	N
Drainage	Y	N
Infection	Y	N
Trauma	Y	N
Sneezing	Y	N
Bleeding	Y	N
Loss of Smell	Y	N
Other ______________	Y	N

Throat:

Symptom		
Lumps/Growth	Y	N
Pain	Y	N
Swelling	Y	N
Dryness/Itching	Y	N
Tonsillitis	Y	N
Hoarseness	Y	N
Voice Change/Loss	Y	N
Frequent Clearing	Y	N
Cough	Y	N
Other ______________	Y	N

Sinus:

Symptom		
Eye/Facial Swelling	Y	N
Change in Vision	Y	N
Pain/Pressure	Y	N
Drainage	Y	N
Headaches	Y	N
Infection	Y	N
Congestion	Y	N
Polyps	Y	N
Other ______________	Y	N

Mouth:

Symptom		
Sores on Tongue	Y	N
Gum Swelling	Y	N
Lumps/Growth	Y	N
Bleeding	Y	N
Loss of Taste	Y	N
Pain	Y	N
Bad Breath	Y	N
Other ______________	Y	N

Eyes:

Symptom		
Watery	Y	N
Drainage	Y	N
Itching	Y	N
Change in Vision	Y	N
Redness	Y	N

Neurological:

Symptom		
Tremors/Seizures	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Headache	Y	N
Other ______________	Y	N

Endocrine:

Symptom		
Diabetes	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Hair Loss	Y	N
Weight Loss	Y	N
Weight Gain	Y	N
Muscle Pain	Y	N
Fatigue	Y	N
Constipation	Y	N
Other ______________	Y	N

Gastrointestinal:

Symptom		
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Night Time Cough	Y	N
Trouble Swallowing	Y	N
Other ______________	Y	N

Skin:

Symptom		
Skin Rash	Y	N
Hives	Y	N
Persistent Itch	Y	N
Other ______________	Y	N

Musculoskeletal:

Symptom		
Joint Pain	Y	N
Neck Pain/Back Pain	Y	N
Muscle Weakness	Y	N
Other ______________	Y	N

Respiratory:

Symptom		
Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other ______________	Y	N

Hematological/Lymphatic:

Symptom		
Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other ______________	Y	N

Psychological/Emotional:

Symptom		
Depression	Y	N
Anxiety	Y	N
Medication	Y	N
Other ______________	Y	N

Allergic/Immunological:

Symptom		
Hay Fever	Y	N
Drug Allergies	Y	N
Food Allergies	Y	N
Other ______________	Y	N

General:

Symptom		
Frequently Tired	Y	N
Night Sweats	Y	N
AIDS	Y	N
Hepatitis	Y	N
Other ______________	Y	N

Cardiovascular:

Symptom		
Chest Pain	Y	N
High Blood Pressure	Y	N
Irregular Heart Rate	Y	N
Other ______________	Y	N