Austin Association of Otolaryngologists, P.A.
Patient Information

Name ____

Address ____

City ______________________________ State ________ Zip ________________

Date of Birth _____/_____/______ SS# ______-____-______ Sex ____

Phone ______________________ Email Address ________________________ @ ____________

Employer ______________________________ Occupation ________________________

Address ____

Guarantor Information (Insurance Card Holder)

Name ______________________________ Date of Birth _____/_____/_________

Relation to Patient ______________________ SS# ______-____-______ Sex ____

Insurance Information

Primary Ins. ______________________ Secondary Ins. ______________________

Policy/Member ID# ______________________ Policy/Member ID# ______________________

Group# ______________________ Group# ______________________

Did a doctor refer you to our office? Yes ______ No _________

If so, who? ______________________ Phone ______________________

Who is your primary (family) doctor? ______________________________

Emergency Contact

Name ______________________ Relationship ________________ Phone ________________

The undersigned hereby assigns to Austin Association of Otolaryngologists, P.A. (AAO) all right, title, and interest in any payment due patient and/or undersigned for medical care, services, or supplies described in any health insurance claim form or statement issued by AAO. The undersigned understands that this agreement will not eliminate or affect in any way the obligation of the patient and/or undersigned to pay AAO for all services and supplies rendered, including but not limited to any co-payments or deductibles required by a particular health care program or plan.

Insured/Patient Signature ______________________________ Date ______________

Release of Medical Information

I hereby authorize the release of any medical record, inclusive of all results of any testing and other pertinent information acquired during my treatment, to the physicians as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature ______________________________ Date __________ Witness ________________

ENT Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. PLEASE FILL OUT EVERY ITEM. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Full Name ____Social Security # ________________________
Male ☐ Female ☐ Date of Birth_____________Pharmacy____________________Phone#__________________
Primary Care Physician______________________Address____________________Phone#__________________
What is the reason you are seeing the doctor today?____

____

____

Are you taking ANY kind of medication now? (Rx, over the counter, herbal supplements, etc.) No ☐ Yes ☐

Medication Name	Dosage	How Often?	Reason for Medication

Are you allergic to any medications? No ☐ Yes ☐

Medication	Reaction (rash, hives, nausea, vomiting, swelling, breathing problems, etc.)

Are you allergic to anything in the environment such as pollens, dust, food, etc? No ☐ Yes ☐
If yes, please list:____

Have you ever had an allergy test? No ☐ Yes ☐

<u>Have you ever been *DIAGNOSED* with any of the following medical problems?</u>

Cancer (type)_________ ☐No ☐Yes What year?_____________

<u>Nose and Sinus</u>
Nasal Allergies ☐No ☐Yes What year?_____________

<u>Heart and Blood Vessels</u>
High/Elevated Cholesterol ☐No ☐Yes What year?_____________
High Blood Pressure ☐No ☐Yes What year?_____________

<u>Lungs and Respiratory</u>
Tuberculosis ☐No ☐Yes What year?_____________

<u>Stomach and Digestive</u>
Duodenal Ulcer ☐No ☐Yes What year?_____________
Hepatitis ☐No ☐Yes What year?_____________
Stomach Ulcer ☐No ☐Yes What year?_____________

<u>Kidney and Gender Problems</u>
Renal Failure ☐No ☐Yes What year?_____________
Are you PREGNANT? ☐No ☐Yes

<u>Mental and Emotional</u>
Depression ☐No ☐Yes What year?_______
Anxiety ☐No ☐Yes What year?_______

<u>Glands, Hormones, and Sugar Control</u>
Diabetes ☐No ☐Yes What year?_______
Thyroid Deficiency ☐No ☐Yes What year?_______
Thyroid Excess ☐No ☐Yes What year?_______

<u>Blood & Lymph Node Problems</u>
Anemia ☐No ☐Yes What year?_______

<u>Allergies, Immune & Infections Problems</u>
HIV ☐No ☐Yes What year?_______
Infectious Mononucleosis ☐No ☐Yes What year?_______

Year	Surgeries	Year	Illnesses Requiring Hospitalization

Problems with Anesthesia Year________Describe____________________

Family History

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister

Ears

Hearing Loss before age 20 ☐Mother ☐Father ☐Brother ☐Sister

Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus

Nasal Allergies ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels

Heart Disease ☐Mother ☐Father ☐Brother ☐Sister

High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory ☐Mother ☐Father ☐Brother ☐Sister

Asthma ☐Mother ☐Father ☐Brother ☐Sister

Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous ☐Mother ☐Father ☐Brother ☐Sister

Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood and Lymph Node Problems

Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister

Other: ______________ ☐Mother ☐Father ☐Brother ☐Sister

Social History:____

What is or was your occupation?______________________________ ☐ Retired?________

Have you ever used tobacco in any form? ☐No ☐Yes

Do you consume alcohol? ☐No ☐Yes

Type of Tobacco	From Year	To Year	Type of Alcohol	How Much	How Often
Cigs/day					
Other:					

Are you exposed to second hand smoke? ☐No ☐Yes

Do you use drugs recreationally? ☐No ☐Yes If yes, please list:______________________________

REVIEW OF SYSTEMS Please ***check boxes AND circle*** those that apply to you

General Health Problems ☐No ☐Yes
(Fever, sleeping problems, unintentional weight loss)

Head or Face Problems ☐No ☐Yes
(Headache, face pain)

Eye Problems ☐No ☐Yes
(Double vision, itchy eyes)

Ear Problems ☐No ☐Yes
(Ear pain, ear drainage, hearing loss, dizziness, ringing)

Nose and Sinus Problems ☐No ☐Yes
(Chronic congestion, hay fever, sinus drainage)

Mouth and Throat Problems ☐No ☐Yes
(Change in voice, snoring, sore throat, ulcers)

Neck Problems ☐No ☐Yes
(Neck masses or lumps, pain, swollen glands)

Heart or Circulation Problems ☐No ☐Yes
(Blacking out or fainting, bluish discoloration of lips or fingernails, chest pain, irregular heartbeat, leg cramps, swelling of ankles)

Lung or Respiratory Problems ☐No ☐Yes
Frequent non-productive cough, frequent productive cough, shortness of breath, wheezing)

Stomach Problems ☐No ☐Yes
(Abdominal pain, diarrhea, heartburn, nausea, vomiting)

Brain or Nervous System Problems ☐No ☐Yes
(Numbness, seizures, severe face pain, weakness)

Problems with Glands, Hormones ☐No ☐Yes
(feel cold all the time, feel hot when others do not, increased appetite, increased fatigue, neck has enlarged, unwanted weight change)

Problems with Blood or Lymph Nodes ☐No ☐Yes
(Bleeds excessively after injury, bruises easily)

Problems with Allergies ☐No ☐Yes
(Food intolerances, frequent sneezing, hives,post nasal drainage, severe reaction to insect bites)

OTHER QUESTIONS/CONCERNS:____

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____

____

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Austin Association of Otolaryngologists, P.A.
Melba F. Lewis, M.D.

ACKNOWLEWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ ________________________

Name of Patient Date

____ ________________________

Signature of Patient or Personal Representative Relationship

OFFICE USE ONLY:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith to obtain such acknowledgement and Record the reason why the acknowledgement was not obtained.

Refused to Sign ☐ Physically Unable to Sign ☐

Employee Signature ____________________________________ Date______________________________

Assignment of Insurance

The undersigned hereby assigns to Austin Association of Otolaryngologists all right, title, and interest in any payment due patient and/or undersigned for medical care, services, or supplies described in any health insurance claim form or statement issued by the indicated entity. The undersigned understands that this agreement will not eliminate or affect in any way the obligation of the patient and/or undersigned to pay the indicated entity for all services and supplies rendered, including, but not limited to, any co-payments or deductibles required by a particular health care program or plan.

Release of Medical Information

I hereby authorize the release of any medical record of all results of any testing and other pertinent information acquired during my treatment to the physician as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Responsibility of Co-Payment/Referrals

Based on the particular plan of insurance carried by the patient and/or insured, and such financial responsibilities set forth within their policy shall be made payable during that particular visit to the physician or provider. These include co-payments, deductibles, and co-insurance when deemed appropriate. The patient and/or insured also agrees that it is their responsibility to obtain any such referrals deemed necessary by their insurance in order to be seen by a provider in this office. Patient and/or insured further agrees to accept financial responsibility for visits that were not prior authorized by their particular insurance plan. *If you need to cancel your appointment, please notify us at least 24 hours in advance of your scheduled appointment. We will asses a $25 fee for each cancellation or no show without the required 24 hour cancellation notice.*

Results of Tests

It is the expressed policy of this office that no patient shall receive the results of any such diagnoistic or laboratory testing by means of telephone or written letter unless previously agreed to and documented in the medical record by the attending physician.

____ ________________________

Insured/Patient Signature Date

____

Witness