ct ENT
Sinus Center | Hearing & Balance

Patient Name:_____ Account No._____ DOB:___/___/___

Initial Visit Medical History Form (p. 1): Please provide the following medical information to the best of your ability:

Date: Age:	List any ALLERGIES TO MEDICATIONS OR LATEX:
What problems are you here for today?	
1)	
2)	
3)	

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes (Circle: type I / type II)	☐	☐		Stomach or Intestinal problems	☐	☐	
Hypertension (high blood press)	☐	☐		Allergy problems/therapy	☐	☐	
Thyroid problems	☐	☐		Kidney problems	☐	☐	
Heart Disease/cholesterol probs	☐	☐		Neurological problems	☐	☐	
Respiratory problems	☐	☐		Cancer	☐	☐	
Bleeding disorder	☐	☐		Other Medical Diagnosis	☐	☐	

2) Please list any operations (and dates) you have ever had *(including tonsils & adenoids)*:

3) Please list any current medications (and amounts, times per day);
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds including sinus/allergy/weight loss meds):

Social History:	Yes	No	Please list details below:
Do you use tobacco?	☐	☐	List type and how much:
If no, did you use it previously?	☐	☐	List type and how much: When did you quit?
Do you drink alcohol?	☐	☐	List type and how much:
What is your occupation?			

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing problems	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	

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Date___/___/___
Patient Name:_____ Account No._____ DOB:___/___/___

Patient Medical History Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

Please check the "Yes" or "No" box to indicate whether you CURRENTLY have any of the following symptoms:

		Yes		Yes
GENERAL	chills	☐	weight loss or gain	☐
	fatigue	☐	daytime sleepiness	☐
ALLERGY	environmental allergy	☐	post-nasal drip	☐
	sneezing fits	☐		
NEURO	headache	☐	weakness	☐
	passing out	☐	numbness, tingling	☐
EYES	eye pain / pressure	☐	vision changes	☐
	watery or itchy eyes	☐		
ENT	hearing loss	☐	ear noises	☐
	dizziness	☐	lightheadedness	☐
	nasal congestion	☐	sinus pressure or pain	☐
	sense of smell problem	☐	problem snoring, apnea	☐
	hoarseness	☐	throat pain	☐
	throat clearing	☐	throat dryness/itching	☐
RESPIR.	cough	☐	coughing blood	☐
	wheezing	☐	shortness of breath	☐
CARDIAC	chest pain	☐	palpitations	☐
	wake short of breath	☐	ankle swelling	☐
GI	difficulty swallowing	☐	heartburn	☐
	abdominal pain	☐	nausea/vomiting	☐
	bowel irregularity	☐	rectal bleeding	☐
HEME/LYM	swollen glands	☐	sweating at night	☐
	bleeding problems	☐	easy bruising	☐
ENDO	feel warmer than others	☐	feel cooler than others	☐
PSYCH	depression	☐	anxiety or panic	☐

PLEASE STOP HERE

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Patient Information

Patient Name_____
Birth date_____ Age_____Male_____Female_____
Address_____ City_____State___Zip_____
Home phone_____Work_____Cell_____

Family Physician_____Referring Physician_____

I agree to allow CT ENT to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize CT ENT to leave messages for me when I am unavailable. Please check appropriate line.

_____Home messages _____Cell messages _____Work messages

I authorize CT ENT and medical staff to discuss my healthcare information(which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicated my choice to be a "No Information" and I do not want any information released to anyone else.

Name _____relationship _____contact info_____
Emergency contact ONLY:
Name:_____ hone_____

By my signature below I acknowledge that I have read and understand the **GUIDELINES TO PATIENT COMMUNICATION** and information provided on this consent form.

INSURANCE INFORMATION

Please complete and present insurance card at the desk.

Primary insured _____Date of Birth:_____
Person responsible for bill:_____
Address if different from patient: _____
Does your insurance require a doctor's referral?_____
If yes, obtaining a referral form your primary physician is your responsibility.

I authorize and request my insurance company to pay directly to The CT ENT any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and agree to assume responsibility for any services not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are **DUE IN FULL AT THE TIME OF SERVICE.**

Signed _____Date:_____
Relation to patient_____

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Credit and Collection Policy Statement

1. **For your convenience, we accept Checks, Cash, all Credit Cards.**
2. **CO-PAYMENTS must be paid in full on the date of service. Co-payments are legally part of your insurance contract and cannot be waived under any circumstances unless your insurance contract stipulates there is no co-payment for services rendered on that day. Co-payments are determined and charged by your insurance company. Co-payments are traditionally charged for rechecks and are always charged for each patient seen. If you have any questions regarding when you owe a co-payment, please contact your insurance company.**
3. **Our office will charge a fee of $25.00 to your account for NSF checks that are returned by the bank. After a NSF check has been returned on your account, we will request payment be made by cash or credit card only.**
4. **If a personal balance for a copay, coinsurance or deductible is due after insurance has responded for a date of service a statement will be sent to the responsible party. Payment in full is expected upon receipt of the first statement. DO NOT DISREGARD ANY STATEMENTS YOU RECEIVE. Our office will make every effort we can to collect a balance before sending to collection, but we need your cooperation.**
5. **Remember that payment arrangements can be made at any point during this process prior to the account being sent to a collection agency. However once these steps have been taken, we cannot reverse the process of collections nor the disengagement from the practice in general.**

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICE. I FURTHER ACKNOWLEDGE THAT A COPY OF THE CURRENT NOTICE WILL BE POSTED IN THE RECEPTION AREA AND THAT I MAY REQUEST A COPY OF ANY AMENDED NOTICE OF PRIVACY PRACTICES AT EACH APPOINTMENT.

SIGNED:_____DATE_____
IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE YOUR RELATIONSHIP_____