# ENT and Allergy Associates of Florida – Patient Information

**Please Fill Out Form Completely**

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

**Salutation:** Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐

**Patient Name:** _____ **Date of Birth:**_____ **Age:**_____

**Sex:** F☐ M☐ **Marital Status:** M☐ S☐ D☐ W☐ Other☐

**Please check appropriate response:**

*** *Race: American Indian/Alaska Native**☐ **Asian**☐ **Black/African American**☐ **Declined to answer**☐

**Native Hawaiian/Pacific Islander**☐ **Other Race**☐ **White**☐

**Please check appropriate response:**

****Ethnicity: Hispanic or Latino**☐ **Not Hispanic or Latino:**☐ **Declined to answer:**☐

**Religion:** _____ **Primary Language:** _____ **Maiden Name:** _____

**Responsible Party/Guarantor Name:**_____

**Patient's Address:**_____

Street City, State Zip

**Patient's 2nd Address:**_____ ☐**Full-time** ☐**Part-time Resident**

**Patient's Phone (Primary)** (_____)_____**Patient's Phone (Cell)** (_____)_____

**Please check your preference on how to contact you: Home Phone:**☐ **Cell Phone:**☐ **Other:** _____

**Email Address:**_____ **Employer Name:**_____

**Emergency Contact:**_____**Relationship:**_____**Phone#**_____

**Whom may we thank for referring you?**_____

**Referring Physician:**_____ **Primary Care Physician:**_____

**Is this visit related to a Work Accident**_____ **Auto Accident** _____ **or Other Accident** _____

**Pharmacy Name**_____**Address:**_____**Tele#**_____

## Insurance Information

**Primary Insurance Company:**_____ **Subscriber's Name:**_____ _____

**Relationship to Patient:**_____**Date of Birth:**_____**ID#**_____**Group#**_____

**Secondary Insurance Company:**_____ **Subscriber's Name:**_____

**Relationship to Patient:**_____ **Date of Birth:**_____**ID#**_____**Group#**_____

**I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to ENT and Allergy Associates of Florida. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.**

**I also authorize my Physician and ENT and Allergy Associates of Florida to photograph me for medically related documentation purposes. Yes**☐ **No**☐

**Signature:**_____**Date:**_____

**ENT and Allergy Associates of Florida**

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# MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:_____ M ☐ or ☐ F

Referring Physician:_____ *Pharmacy Name _____

*Pharmacy Cross Street_____

*Pharmacy Phone Number_____

Primary Care Physician:_____ **Weight:** _____ **Height**: _____

**Briefly,** why are you seeing our physician today? _____

**1. Patient History -** Please check your response

| | Yes | No |
|---|---|---|
| Cancer (enter details below) | ( ☐ ) | ( ☐ ) |
| Heart (enter details below) | ( ☐ ) | ( ☐ ) |
| Cardio: Hypertension | ( ☐ ) | ( ☐ ) |
| Ear: Dizziness | ( ☐ ) | ( ☐ ) |
| Ear: Hearing Loss | ( ☐ ) | ( ☐ ) |
| Ear: Tinnitus/Ringing in Ear | ( ☐ ) | ( ☐ ) |
| Endocrine: Diabetes | ( ☐ ) | ( ☐ ) |
| Endocrine: Thyroid Disorders | ( ☐ ) | ( ☐ ) |
| G.I.: Bowel Disorders | ( ☐ ) | ( ☐ ) |
| G.I.: Liver Disorders | ( ☐ ) | ( ☐ ) |
| G.I.: Stomach Disorders/Ulcers | ( ☐ ) | ( ☐ ) |
| G.I.: Reflux/GERD/Heartburn | ( ☐ ) | ( ☐ ) |
| Immuno: HIV | ( ☐ ) | ( ☐ ) |
| Immuno: Immune Dieases | ( ☐ ) | ( ☐ ) |
| Lymph: Anemia | ( ☐ ) | ( ☐ ) |
| Lymph: Bleeding Disorders | ( ☐ ) | ( ☐ ) |

| | Yes | No |
|---|---|---|
| Nasal: Allergies | ( ☐ ) | ( ☐ ) |
| Nasal: Nasal Trauma | ( ☐ ) | ( ☐ ) |
| Nasal: Nose Bleeds | ( ☐ ) | ( ☐ ) |
| Nasal: Sinusitis | ( ☐ ) | ( ☐ ) |
| Neuro: Headaches/Migraines | ( ☐ ) | ( ☐ ) |
| Neuro: Nervous System | ( ☐ ) | ( ☐ ) |
| Neuro: Seizure Disorder | ( ☐ ) | ( ☐ ) |
| Ophth: Eyes/Glaucoma | ( ☐ ) | ( ☐ ) |
| Oral: Sleep Apnea | ( ☐ ) | ( ☐ ) |
| Pysch:PsychiatricDisorders | ( ☐ ) | ( ☐ ) |
| Pulm: Lungs | ( ☐ ) | ( ☐ ) |
| Pulm: Tuberculosis | ( ☐ ) | ( ☐ ) |
| Uro:Bladder Disorders | ( ☐ ) | ( ☐ ) |
| Uro: Kidney | ( ☐ ) | ( ☐ ) |

Other:_____

Details of Yes answers:_____

_____

**2. Surgeries -** Please list any surgeries/hospitalizations: _____

_____

**3. Social History -** Are you a current smoker? ( Y☐ or ☐N ) You now smoke _____ packs of cigarettes a day.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per ☐ day / ☐ week / ☐ month (check one).

How many caffeinated beverages do you drink per day? _____

**4. Family History -** Please check your response

| | Yes | No |
|---|---|---|
| Allergies | ( ☐ ) | ( ☐ ) |
| Cancer | ( ☐ ) | ( ☐ ) |
| Diabetes | ( ☐ ) | ( ☐ ) |
| Headaches/Migraine | ( ☐ ) | ( ☐ ) |
| Immune Disease | ( ☐ ) | ( ☐ ) |

| | Yes | No |
|---|---|---|
| Premature Hearing Loss | ( ☐ ) | ( ☐ ) |
| Sinusitis | ( ☐ ) | ( ☐ ) |
| Sleep Apnea | ( ☐ ) | ( ☐ ) |
| Thyroid Disorders | ( ☐ ) | ( ☐ ) |

Details of Yes answers:_____

**Patient Signature:** _____ Date: _____

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**ALLERGY & MEDICATION LIST**

*Place label here/or patient full name/account number*

**ALLERGIES:**

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

☐ **No Known Drug Allergies**

**MEDICATIONS: Date: _____ Reconciled by:_____**

| Medication Name | Rx = Prescription<br>OTC = Over the Counter,<br>Vitamin/Mineral, Herb<br>Dietary Supplement | Dose | Frequency | Route:<br>Oral, topical,<br>Injection,<br>Inhalation |
|---|---|---|---|---|
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## Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

**Please check response:** ☐ **Yes** ☐ **No**

**Patient/Guardian Signature: _____**

**Print Patient Name: _____ D.O.B:_____**

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(Print Patient Name)

D.O.B: _____

## Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

## Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

## Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

## Message Consent

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_____
**(Print Patient Name)**

**D.O.B: _____**

_____
**Patient Initials**

## PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida to request and use my prescription medication history from other health care providers and/or third party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

## Appointment Reminders

ENT and Allergy Associates of Florida uses a third party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

## Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- ☐ Financial Consent
- ☐ Privacy Consent
- ☐ Consent for Treatment
- ☐ PBM Consent
- ☐ Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

**Patient/ Guardian Signature:_____ Date:_____**

## Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

**Patient/ Guardian Signature:_____ Date:_____**