Demographic and Insurance Form

Note: Children under age 18 must be accompanied by a parent or guardian.

TODAYS DATE: ______________________

PATIENT NAME ______________________
LAST FIRST MIDDLE INITIAL

HOME ADDRESS ______________________
STREET CITY/STATE ZIP

HOME PHONE ____ WORK PHONE ____ CELL PHONE ____

SOCIAL SECURITY # ____ DATE OF BIRTH ____ AGE ____ GENDER ____ MARITAL STATUS ____

EMAIL ADDRESS ____

PRIMARY CARE or REFERRING PHYSICIAN NAME ____

Are any family members current patients?
☐ Yes
☐ No If yes, who? ____

INSURANCE INFORMATION

PRIMARY Name of Insurance: ______________________

NAME OF INSURED ____ INSURED EMPLOYER ____ INSURED DOB ____ INSURED SSN ____

SECONDARY Name of Insurance" ______________________

NAME OF INSURED ____ INSURED EMPLOYER ____ INSURED DOB ____ INSURED SSN ____

COMPLETE ONLY IF PATIENT IS A MINOR

MOTHER'S NAME	____	FATHER'S NAME	____
MOTHER'S DOB	____	FATHER'S DOB	____
MOTHER'S ADDRESS	____	FATHER'S ADDRESS	____
MOTHERS'S PHONE #	____	FATHERS' PHONE #	____
MOTHER'S SSN		FATHER'S SSN	

EMERGENCY CONTACT

NAME ______________________

RELATIONSHIP TO PATIENT ______________________

PHONE NUMBER ______________________

PREFERRED FACILITIES

LAB ______________________

IMAGING ______________________

HISTORY FORM

E·N·T of ATHENS

PCP / Referring Physician: ____________________

Name: ____________________ DOB: ____________

What is the reason for your visit today? (Please describe your symptoms) ____________________

____

____

How long have you had these symptoms? ____________ Are you currently pregnant? ☐ YES ☐ NO

Have you had any of the following: ☐ Allergy Testing WHEN & WHERE ____________

☐ Imaging Scans WHEN & WHERE ____________ ☐ Lab Tests / Cultures WHEN & WHERE ____________

☐ Ultrasounds WHEN & WHERE ____________ ☐ Sleep Studies WHEN & WHERE ____________

Past Medical History:

☐ Nasal Allergies
☐ Asthma
☐ Coronary Artery Disease
☐ Atrial Fibrillation
☐ High Blood Pressure
☐ MRSA
☐ Heart Failure
☐ Diabetes
☐ Reflux
☐ ADD/ADHD
☐ HIV
☐ Hepatitis C
☐ Eczema
☐ Thyroid Disorder
☐ Heart Attack
☐ Autoimmune Disorder
☐ Stroke
☐ Kidney Disease
☐ Bleeding Disorder
☐ Heart Murmur
☐ Hearing Loss
☐ Sleep Apnea
☐ Meniere's Disease
☐ Problems with Anesthesia
☐ Cancer (what site?) ____________
☐ Other ____________

Previous Surgeries and Dates:

	DATE		DATE		DATE		DATE
☐ Tubes in ears	____	☐ Dental surgery	____	☐ Pacemaker	____	☐ Septoplasty	____
☐ Cancer surgery	____	☐ Ear drum repair	____	☐ Hysterectomy	____	☐ Sinus surgery	____
Type: ____________		☐ Heart bypass	____	☐ Joint replacement	____	☐ Tonsillectomy	____
☐ Carotid surgery	____	☐ Heart stent	____	☐ Mastoidectomy	____	☐ Adenoidectomy	____
☐ Cervical spine surgery	____			☐ Neck Mass Removal	____	☐ Thyroidectomy	____

☐ Other ____________________

Family History:

☐ Allergy
☐ Asthma
☐ Bleeding Disorder
☐ High Blood Pressure
☐ Heart Disease
☐ Hearing Loss
☐ Problems with Anesthesia
☐ Thyroid Disorder
☐ Cancer (what type)? ____________
☐ Diabetes

Social History: (please indicate quantity consumed where necessary)

☐ Tobacco Products ☐ Never ☐ Past How long? ________ How much? ________

☐ Personal Use of Recreational Drugs? ☐ NO ☐ YES

☐ Alcohol Use: ☐ Never ☐ Weekly ☐ Daily ☐ Occasionally

Review of Symptoms: (Please check all symptoms experienced in the last 7 days.)

Constitutional:	☐ Fevers ☐ Chills	☐ Weight Loss	☐ Fatigue	
Eyes:	☐ Changes in vision	☐ Blurred vision	☐ Excessive tearing	
Cardiovascular:	☐ Swelling of extremities	☐ Heart murmur	☐ Light-headedness	
Respiratory:	☐ Shortness of breath	☐ Cough	☐ Wheezing	☐ Hoarseness
Gastrointestinal:	☐ Vomiting	☐ Constipation	☐ Diarrhea	☐ Heartburn
Skin:	☐ Rash	☐ Itch	☐ Changes in mole or skin	
Neurologic:	☐ Speech difficulties	☐ Seizure	☐ Loss of Consciousness	
Musculoskeletal:	☐ Limitation of motion	☐ Muscular weakness	☐ Arthritis	☐ Loss of Balance
Hematologic-Lymphatic:	☐ Easy bleeding	☐ Known bleeding disorders		
Allergic-Immunologic:	☐ Sinus allergy symptoms	☐ Allergic dermatitis	☐ Frequent Illness	

CURRENT MEDICATIONS

These forms **MUST NOT** be returned via email. They must be brought with you to your appointment.

NAME: ______________________ DATE OF BIRTH: ____________ DATE: ____________

PREFERRED PHARMACY (Name and Phone Number): ______________________________

DRUG ALLERGIES: ☐ No Drug Allergies

Allergy	Reaction

Name of Drug	Dosage (Strength)	Frequency (times per day)

150 Nacoochee Ave. Athens, GA | Phone: (706)546-7908 | Fax: (706)546-1944

Medical Records Release Form

Release of Protected Health Information

I authorize the release of information including history/physical examination, laboratory tests, x-ray reports, operative reports, pathology, and claims information.

This information may be released to (check all that apply):

- ☐ Myself - Records given directly to the patient, guardian if patient is a minor
- ☐ Spouse Names of spouse/s: ______________________
- ☐ Children Names of children: ______________________
- ☐ Other ______________________
- ☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Authorization to Leave Messages

Please call my:

- ☐ Home ( ) - ______________________
- ☐ Work ( ) - ______________________
- ☐ Cell ( ) - ______________________

If unable to reach me:

- ☐ Please leave a detailed messaged.
- ☐ Please leave a message asking me to return your call.

Patient/Guardian Printed Name ______________________ Date: ____________

Patient/Guardian Signature ______________________ Date: ____________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been made aware of ENT of Athens' Notice of Privacy Practices and acknowledge that it is posted in the waiting room, available on the website (entofathens.com) and I may request a paper copy of the privacy notice at this location. I understand that I may address any questions or concerns I may have about the Notice to the Practice's Compliance Officer.

Patient/Guardian Printed Name ______________________________ Date: __________

Patient/Guardian Signature ______________________________ Date: __________

E·N·T of ATHENS

ENT of Athens No-Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, ENT of Athens sends Text messages, Voice messages and email reminders 6 days and 4 days in advance of the appointment time. ENT of Athens also calls 3 days in advance of the appointment time as well.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least **24 hours** notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a **$25.00** "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it and cannot be seen until it is paid.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of ENT of Athens. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge of **$25.00**.

Patient Name (print) ______________________ Date ______________

Patient Signature ______________________

Agreement of Financial Responsibility
for In-Office Procedures

I understand that my insurance may not cover some in-office procedures under my copay. Instead, they may count toward my deductible.

At ENT of Athens, the most common procedures in this category are:

- Nasal Endoscopy
- Flexible Laryngoscopy
- Audiology (hearing) testing
- Cerumen removal (ear wax removal)

I understand that these procedures may be part of my appointment.

I understand that my provider may need to do these procedures to find out what is causing my problem.

I know I can ask for more information about the cost of these procedures.

I agree to pay for any services I receive. The cost will depend on my insurance and how much of my deductible I have left.

Signature of Patient /Responsible Party ______________________ Date ______________________

Name of Patient/Responsible Party (please print) ______________________ Relationship to Patient ______________________

E·N·T of ATHENS

I hereby authorize ENT of Athens to obtain medical records and pharmacy records from other sources as may be needed in the treatment of this patient. I hereby authorize ENT of Athens to provide all necessary treatment for this patient. I hereby authorize ENT of Athens to release any medical information to my insurance company or physicians involved in the care and treatment of this patient. I understand that I am responsible for ALL charges. I authorize ENT of Athens to file my insurance on my behalf. In the event that my insurance company does not pay for any services rendered, I am responsible for those charges. I understand that it is my responsibility to notify the office of any change, such as address, phone numbers, family doctor, and insurance plans. I understand that if my insurance requires a referral, then it is up to me to make sure this is done. I also understand that if I change insurance companies or family physician, them my current referral is VOIDED. I must contact my current family doctor to get a new referral. I understand if I fail to notify the office of any changes that I will be held accountable for those charges.

PATIENT SIGNATURE: ______________________________

RELATIONSHIP TO PATIENT (IF NOT PATIENT SIGNATURE) ______________________