ENT and Allergy Associates of Florida

ACCOUNT# _____

Medical History Form

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ **M** ☐ **F**

Referring Physician: _____ Primary Care Physician: _____

Pharmacy Name_____Address:_____Tele# (_____)_____

Weight: _____ **Height:** _____ Email Address: _____

Reason for visit: _____

How Long: _____How Severe_____

Previous treatment for this problem or have you had any diagnostic testing performed?

_____

If female, are you pregnant? ☐**Yes** ☐**No** **Are you allergic to latex?** ☐**Yes** ☐**No**

Do you take any herbal or homeopathic remedies? ☐Yes ☐ No If so, what? _____

Are you allergic to any medications or drugs? ☐**Yes** ☐**No** _____

Reaction: _____

Patient History – Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	HIV	( )	( )
Anemia	( )	( )	Immune Disease	( )	( )
Bleeding Disorders	( )	( )	Kidney _____	( )	( )
Bowel Disorders	( )	( )	Liver Disorders	( )	( )
Bladder Disorders	( )	( )	Lungs (Emphysema)	( )	( )
Cancer _____	( )	( )	Pneumonia/ Bronchitis	( )	( )
Diabetes (Type _____)	( )	( )	Tuberculosis	( )	( )
Dizziness	( )	( )	Neck Pain	( )	( )
Eyes/ Glaucoma	( )	( )	Nasal Trauma	( )	( )
Ear Pain	( )	( )	Nose Bleeds	( )	( )
Ear Ringing/ Tinnitus	( )	( )	Sleep Apnea	( )	( )
Reflux/ GERD/ Heartburn	( )	( )	Snoring	( )	( )
Stomach Disorders/Ulcers	( )	( )	Sinusitis	( )	( )
Heart _____	( )	( )	Seizure Disorder	( )	( )
Hypertension	( )	( )	Nervous System	( )	( )
Headaches/Migraines	( )	( )	Psychiatric Disorders	( )	( )
Hearing Loss	( )	( )	Thyroid Disorders	( )	( )

Other:_____

SURGERIES/OPERATIONS *(PLEASE LIST)*

_____ Approximate Date _____

_____ Approximate Date _____

_____ Approximate Date _____

_____ Approximate Date _____

_____ Approximate Date _____

Patient Name: _____ DOB: _____ ACCT# _____

Social History (Please check all that apply)

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.
Do you consume alcohol? (Y or N) How many drinks per day**? 1 or less** per day**, 1-2** per day**, 3 or more** per day
How many caffeinated beverages do you drink per day? _____

Family History (Please check all that apply)

	Yes	No		Yes	No
Allergies- Environmental	( )	( )	Head/Neck Cancer	( )	( )
Allergies- Food	( )	( )	Headaches / Migraines	( )	( )
Anesthesia Problems	( )	( )	Immune Disease	( )	( )
Asthma	( )	( )	Premature Hearing Loss	( )	( )
Bleeding Disorders	( )	( )	Sinusitis	( )	( )
Cancer _____	( )	( )	Sleep Apnea	( )	( )
Diabetes (Type_____)	( )	( )	Thyroid Disorders	( )	( )

Please specify which immediate family member and what condition: _____
_____
_____
_____

PRESENT MEDICATIONS

Please list medication name and dosage	**Frequency**
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY

ENT and Allergy Associates of Florida
Caring For Our Patients Since 1963
www.entaaf.com **www.otodocs.com**

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Patient Information

Please Fill out Form Completely **Account #**_____

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

Sex: ☐ **M** ☐ **F** **Marital Status: S** ☐ **M** ☐ **D** ☐ **W** ☐ **Other**_____ **Please check appropriate response:**

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

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

*****Race:** American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐

Native Hawaiian/Pacific Islander ☐ Declined to answer ☐ Other Race ☐

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

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

Email Address:_____

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

Whom may we thank for referring you?_____

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

Employer Name:_____ Phone # (_____)_____

Is this visit related to a: ☐ Work Accident ☐ Auto Accident ☐ 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:**_____

Account # _____

Privacy Consent/ Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this Practice are entitled to the greatest degree of privacy possible. The release of medical information to any insurance carrier, other entities directly associated with the offices of ENT and Allergy Associates of Florida, primary care provider and/or referral physician in connection with treatment is authorized. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. No other disclosures will be made without written authorization from the patient or guardian. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours and to make comments to the same. All requests must be made in writing.

Consent for Photographs

I consent that photographs may be taken of me or parts of my body, under the following conditions: 1. the photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her. 2. The photographs shall be used for medical records and, if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he/she may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name reasonable steps shall be taken to preserve my identity.

In each case, the Practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I have read and understand the above. I further understand that I have been given access to the physician's privacy notice and that a copy of which was available for my taking in the Patient's Bill of Rights Notebook. I have had the opportunity to place special restrictions upon the consent hereby given. I further understand that special requests for restrictions must be submitted to the Practice in writing.

Appointment Reminders and Message Consent

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. 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. ☐**Yes** ☐**No**

*****I also hereby authorize the disclosure of Personal Health Information to the individual(s) listed below and via answering machine and/or email unless specifically excluded below.*****

◊_____**Birthday:**_____ ◊_____**Birthday:**_____

◊_____**Birthday:**_____ ◊_____**Birthday:**_____

Special Restrictions: _____

Pharmacy Benefits Managers (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 payers 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.

Patient/ Guardian Signature _____**Date** _____

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

Account #_____

Consent for Treatment and Release of Information

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), taking of x-rays, ultrasounds, CT's, allergy testing and treatment, and administration of medications prescribed by the physician. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

In connection with the medical services that I am receiving from the above named physician or physician group, I hereby authorize the above-named physician and/ or group/associates to disclose any/all information concerning my medical condition and treatment (including, but not limited to, super confidential information concerning sexually transmitted disease, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to: any third party payer covering the medical services of the patient; other health care professionals and institutions involved in the delivery of health care; the proponent of any legally sufficient subpoena, or in response to a court order; employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services; pharmacies; and as otherwise required by law.

Medicare Consent

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.

Medicare patients are responsible for meeting an annual deductible of $183.00. Once your deductible has been satisfied, Medicare will pay at a rate of 80% of the submitted claim and patients will be responsible for paying their 20% at the time of the visit. As a courtesy, we will file secondary insurances.

Financial Consent

Providing the highest quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. Unfortunately, if you do not inform us of special requirements necessary by your plan, and we order services such as laboratory, supplies, x-ray, etc. that are not covered by your plan, payment for these services will be your responsibility.

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 and co-pays, and that full payments are due at the time of services are 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.

Patient/ Guardian Signature _____**Date** _____

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

Account #_____

Payment Policy

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient or the financially responsible party, being responsible for all cost incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out whether or not we are providers for your specific network. You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at the time of service. Because we are specialists, some diagnostic/ invasive procedures, may not be considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage to avoid confusion and out of pocket expense.**

Referrals→ If you need a referral from your insurance company or from your Primary Care Physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you may be required to reschedule your appointment should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us.

Non-Participating Provider Policy→ If we are not a provider for your insurance company, we will collect our fees in full at the time of Service.

◊ I hereby acknowledge that I am responsible, and it is in my best medical interest to attend any scheduled appointments and/or follow-up appointments with ENT and Allergy Associates of Florida as recommended by my Physician. I further understand that if my Physician orders/recommends out-patient diagnostic imaging testing, a sleep study, allergy or laboratory testing, or Audiology testing, it is because he/she feels that it is in my best interest.

◊ I understand that the Practice has a "no-show" policy in effect, which requires twenty-four (24) hours' notice if I must cancel my appointment. A $100.00 charge will be assessed if I "no-show" for Allergy Testing, Diagnostic Audiology, and Ultrasounds. A cancellation fee of $100 will be charged in the event that you cancel your surgery once an operative date has been established.

◊ There is a charge for the completion of forms, $10.00 for 1 page and $25.00 for 2 or more pages.

Consent Forms Acknowledgement

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

□ Privacy Consent □ Message Consent □ PBM Consent □ Consent for Treatment □ Financial Consent

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

Patient/ Guardian Signature _____Date _____

Print Patient Name _____ D.O.B_____