PATIENT INFORMATION FORM

Not filling out this form may delay or result in non-payment of insurance benefits leaving you responsible for services rendered

Last Name _____ First Name _____ MI_____

Maiden Name_____ Social Security # _____–_____–_____

DOB _____/_____/_____ Age _____ Ethnicity _____ Gender ☐Male ☐Female Marital Status ☐S ☐M ☐W ☐D

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Preferred Phone (_____)_____ Secondary Phone (_____)_____

Email _____

Emergency Contact _____ Relationship _____ Phone (____)_____

Referring Physician _____ Primary Care Physician _____

****Required Information for Minor Patient (Under 18 yrs.)*****

Mother/Guardian's Name _____ Phone (____)_____

Address (if different from above) _____

Father/Guardian's Name _____ Phone (____)_____

Address (if different from above) _____

INSURANCE INFORMATION - Please Present Receptionist with Your Insurance Card(s)

Primary Insurance _____ID # _____Group #_____

Policy Holder's Name_____ DOB _____/_____/_____

Secondary Insurance _____ID # _____Group #_____

Policy Holder's Name_____ DOB _____/_____/_____

PHARMACY INFORMATION

Preferred Pharmacy _____ Address _____

Prescription/Drug Coverage _____ID # _____Group #_____

FINANCIAL AGREEMENT

1. As a courtesy to all our patients a claim with your insurance company will be filed on your behalf. Seeing an out-of-network provider may result in reduced or denied benefits. You are responsible for any bill or portion of a bill that is not paid by your insurance company. If we do not participate with your insurance, we do not accept any fee schedule reductions and you are responsible for the full amount of billed charges.
2. We are obligated by contract to collect co-payments (co-pays) at the time of service, so please bring your co-pay with you. You may be required to pay deductible and/or co-insurance at the time of service.
3. We require written approval/authorization by your employer and/ or worker's compensation carrier PRIOR to your initial visit. If your claim is denied, you will be responsible for payment in full.
4. Should your insurance company determine a charge to be non-covered, you are responsible for full payment of said charge.
5. Accounts 90 days outstanding will bear interest charges of 1% per month or 12% per annum.
6. Returned checks will be subject to a $35 fee.
7. Deposits for surgical procedures are due seven days prior to surgery.
8. By signing below, you give your permission to ENTSA and its Affiliates or contractors to contact you for any purpose at the current or at any future numbers that are provided for your landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or text messages (Standard telephone and text charges may apply).

AUTHORIZATION & RELEASE

I certify the information on this form is accurate and complete to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay the bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I also understand I am responsible for all second opinion and pre-admission review requirements. I acknowledge that Ear, Nose & Throat Surgical Associates have provided me a copy of their Privacy Practices.

Signature: _____ Date: _____

Ear, Nose & Throat
Surgical Associates, S.C.
1320 North Meade Street, Appleton, WI 54911
(920) 734-7181

NAME _____
DATE _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of the Notice of Privacy Practices is to describe to you how Ear, Nose & Throat Surgical Associates may use and disclose your protected health information, certain restrictions on the use and disclosure of your healthcare information and your rights regarding protected health information. Ear, Nose & Throat Surgical Associates will not make any unapproved disclosure of your PHI without your written authorization.

I hereby agree to permit Ear, Nose & Throat Associates to disclose my medical and billing protected health information to the following:

(Example: spouse, parent, relative, grandparent, friend etc.)

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

☐ Declined

Sign: _____ Date: _____

5/25/16

Name: _____ DOB: _____

What is the reason for your visit today? _____

MEDICAL HISTORY/FAMILY HISTORY

Please circle the family member(s) in which the condition applies

Diabetes	Self/Mother/Father/Bro/Sis	Bleeding Problems	Self/Mother/Father/Bro/Sis
Heart Disease	Self/Mother/Father/Bro/Sis	Anesthesia Problems	Self/Mother/Father/Bro/Sis
High blood pressure	Self/Mother/Father/Bro/Sis	Kidney Disease	Self/Mother/Father/Bro/Sis
Lung/Asthma	Self/Mother/Father/Bro/Sis	Stroke	Self/Mother/Father/Bro/Sis
Hearing Loss	Self/Mother/Father/Bro/Sis	Thyroid	Self/Mother/Father/Bro/Sis
Cancer	Self/Mother/Father/Bro/Sis	Dementia/Alzheimer's	Self/Mother/Father/Bro/Sis
*AIDS/HIV	SELF-YES/NO	*HEPATITIS C	SELF-YES/NO

List past surgeries/hospitalizations:

☐ No Past Surgeries/hospitalizations

_____

_____

_____

_____

_____

_____

Social History:

Do you smoke? ☐ YES ☐ NO

Former Smoker? ☐ YES ☐ NO Quit Date_____

NEVER a Smoker ☐

Do you drink alcohol? ☐ YES, number of drinks per week_____

☐ NO

Occupation _____

MEDICATIONS (PLEASE INCLUDE DOSAGE)

☐ NOT CURRENTLY TAKING MEDICATIONS _____

_____

_____

_____

_____

MEDICATION ALLERGIES

LATEX ALLERGY? ☐ Yes ☐ No

☐ NO KNOWN DRUG ALLERGIES _____

_____

REVIEW OF SYSTEMS

ARE YOU *CURRENTLY* HAVING ANY OF THE FOLLOWING PROBLEMS? *(PLEASE CHECK)*

GENERAL
- ☐ Fever greater than 99°
- ☐ Unexplained weight loss
- ☐ Fatigue/Weakness

EYES
- ☐ Dry or itchy eyes
- ☐ Decreased vision

EARS
- ☐ Ringing or noise in the ears
- ☐ Ear Pain or drainage
- ☐ Hearing Loss

NOSE
- ☐ Blocked or runny nose
- ☐ Loss of smell
- ☐ Nose bleeds

THROAT
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Hoarse/Rough voice
- ☐ Frequent throat-clearing

LUNGS
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma

STOMACH
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea or vomiting
- ☐ Bloody stools

BONES AND MUSCLE
- ☐ Arthritis
- ☐ Muscle Pain

SKIN
- ☐ Changes in mole or wart
- ☐ New skin growth

HEART
- ☐ Chest pain with activity
- ☐ Irregular heart beat

NEURO
- ☐ Change in facial muscle strength
- ☐ Loss of facial sensation
- ☐ Headaches

ALLERGY/IMMUNO
- ☐ Seasonal allergies