PATIENT INFORMATION

ID# ________________

PATIENT NAME: Last ________________________________ First __________________________ MI ______

Social Security No. ____________ /_________/_______________ **Patient's Age** ___________________________

STREET ADDRESS: ____

City _____________________________________ **State** ________________ **ZIP Code** _____________________

Home Phone _____________________________________ **Cell/Work Phone**___________________________________

Date of Birth ___/___/___ **Male** ____ **Female** ____ **MARITAL STATUS** ____ **S** ____**M** ____**D** ____**W**

Which Doctor Are You Seeing Today? ____**Dr. Locandro** ____ **Dr. Parikh** ____ **Dr. Kauffman** _____**Dr. Ingley**

PRIMARY CARE PHYSICIAN: ____ **Phone No.** _______________________

REFERRING PHYSICIAN if different from PCP: ____

E-Mail Address _____________________________________ **How Did You Hear About Us?** _______________________

RESPONSIBLE PARTY NAME: Last _________________________________ **First** ____________________ **MI** ______

Date of Birth ____/____/____ **Male** ____ **Female** _____ **Social Security No.** ___________/________/___________

HOME PHONE (_______**)**_______________________ **WORK PHONE (**_____**)**_____________________**Ext**________

STREET ADDRESS ____

ZIP Code _________________ **City** ____ **State** ___________________

Primary Insurance Co. ____ Policy Holder ________________________**

Policy ID# ____ Group No. ___________________________

Secondary Insurance Co. ____ Policy Holder_______________________**

Policy ID# ____ Group No. ___________________________

**** If Policy Holder is not the Patient, We Must Have the Following Information to File Your Claim****

POLICY HOLDER: Last ______________________________________First ___________________________ MI ________

Date of Birth ______/_____/___________ **Sex** ___ **Male** ___ **Female** **Social Security No.** _________ /______/____________

PATIENT'S RELATIONSHIP TO POLICY HOLDER ___**Spouse** ___ **Child** ___ **Other** ___________________________________

PATIENTS EMPLOYER ____

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Northwest ENT and Allergy Center to diagnose and treat me. I also authorize Northwest ENT and Allergy Center to release medical and/or any other information to my insurance carrier, Medicare, and/or the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for payment on Medicare/Insurance Company Claims for services rendered by Northwest ENT and Allergy Center and/or it's physicians. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to Northwest ENT and Allergy Center and/or it's physicians. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws.

____ ___________________________

Patient or Legal Guardian Signature (If patient under 18 years old) Date

NORTHWEST ENT AND ALLERGY CENTER **PATIENT MEDICAL HISTORY** **DATE: ___ - ___ - _____**

Name: ______________________________________ ❒M ❒F **Age:** ______ **DOB:** ___ - ___ - _____

❒Drew Locandro, MD ❒Shatul Parikh, MD ❒Ryan Kauffman, MD ❒Avani Ingley, MD

Primary Care Physician: ____ (❒none)

Referring Physician/Practice Name: ________________________________ (❒none or ❒PCP above)

Reason for Visit: (include description of problem, onset, location, frequency, severity, other signs, treatments)

____

____

____

Medical History: (❒no other medical problems) ❒hypertension ❒heart disease ❒diabetes ❒asthma ❒COPD ❒ ↑cholesterol ❒kidney disease ❒allergic rhinitis ❒thyroid disease ❒migraines ❒sleep apnea (CPAP ❒yes ❒no) ❒cancer _____________________ ❒______________________ ❒______________________ ❒________________________

____

Previous Surgery: (❒none) ❒tonsils ❒adenoids ❒ear tubes ❒ear surgery ❒nasal/sinus surgery ❒vocal cord ❒thyroid ❒neck surgery ❒______________________ ❒_________________________ ❒______________________________

____

Family History: (❒none) or anything related to visit: ____

Social History: Alcohol: ❒never ❒minimal ❒less than 10/week ❒more than 10/week

Tobacco: ❒never ❒minimal ❒yes ___packs/day x ___yrs ❒quit ___yrs ago (___packs/day x ___yrs)

Current Medications: (❒none) _____________________ _____________________(❒see attached) ___________________

________________________________ _____________________________________ ___________________________________

Drug Allergies: (❒none) _________________________ _________________________ ______________________________

__________________________ ________________________ ________________________ ___________________________

General		**Respiratory**		**Lymphatic/Blood**		**Gastrointestinal**	
Weight change	❒yes ❒no	Cough	❒yes ❒no	Swollen glands	❒yes ❒no	Indigestion	❒yes ❒no
Fever	❒yes ❒no	Short breath	❒yes ❒no	Excess bleeding	❒yes ❒no	Nausea	❒yes ❒no
Fatigue	❒yes ❒no	Wheezing	❒yes ❒no	Excess bruising	❒yes ❒no	Swallowing prob	❒yes❒no

Cardiovascular		**Neurologic**		**Eye**		**Endocrine**	
Chest pain	❒yes ❒no	Headaches	❒yes ❒no	Eye pain	❒yes ❒no	Bone pain	❒yes ❒no
Palpitations	❒yes ❒no	Lightheaded	❒yes ❒no	Double vision	❒yes ❒no	Cold sensitive	❒yes ❒no
Leg swelling	❒yes ❒no	Numbness	❒yes ❒no	Dry eye	❒yes ❒no	Hair/skin change	❒yes ❒no

Ear Nose Throat				**Allergy**		**Sleep**	
Hearing loss	❒yes ❒no	Nasal obstruction	❒yes ❒no	Sneezing	❒yes ❒no	Loud snoring	❒yes ❒no
Tinnitus	❒yes ❒no	Nasal drainage	❒yes ❒no	Mouth breathing	❒yes ❒no	Interrupted	❒yes ❒no
Vertigo	❒yes ❒no	Nosebleeds	❒yes ❒no	Seasonal	❒yes ❒no	Un-refreshed	❒yes ❒no
Ear pain	❒yes ❒no	Facial pain	❒yes ❒no	Allergy shots	❒yes ❒no	Day sleepiness	❒yes ❒no
Ear drainage	❒yes ❒no	Postnasal drainage	❒yes ❒no	Previous testing	❒yes ❒no______________		
Sore throat	❒yes ❒no	Smell/taste change	❒yes ❒no	results:______________			
Neck mass	❒yes ❒no	Hoarseness	❒yes ❒no				

Please enter: height ____ ft ____ in, weight_____ lbs (staff use: BMI___ T___ RR ___ P___ BP ____/____)

Patient/guardian signature ____

(DX ❑min(x2max)x1, ❑est stbx1, ❑est worsx2, ❑newx3, ❑new wkupx4______________________________________

DATA ❑lab ❑rad ❑proc ❑md dis ❑req MR ❑rev MRx2 ❑view x2 _____________RISK ❑min ❑low ❑mod ❑high)_______________

PMH reviewed / completed by ________________________MD rev 12/11

NAME:_________________________________ **DATE:** __________ **AGE:** ____ **Sex:** ____ **HEIGHT:** _____ **WEIGHT:** _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how you would have been affected. **Use the following scale to choose the most appropriate number for each situation**:

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_______
Watching TV	_______
Sitting inactive in a public place (e.g., a theater or a meeting)	_______
As a passenger in a car for an hour without a break	_______
Lying down to rest in the afternoon when circumstances permit	_______
Sitting and talking to someone	_______
Sitting quietly after a lunch without alcohol	_______
In a car, while stopped for a few minutes in the traffic	_______
Total	_______

PATIENT CONFIDENTIALITY

To ensure there is no violation of your privacy, please provide us with the following information:

In the event that I, ____ cannot be reached, Northwest ENT Associates, P.C. may leave any test result, lab result, appointment information, or other confidential medical or financial information with the following:

Please circle all that apply:

SPOUSE　　　　　　　　CHILDREN OR OTHER FAMILY MEMBER

HOME VOICE MAIL　　　WORK VOICE MAIL　　　CELL VOICE MAIL

OTHER: ____

If there is anyone you **DO NOT** wish for us to discuss this information with, please specify below:

PATIENT SIGNATURE:____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:____Date:____________________

Relationship (if not signed by patient):_______________________________________

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time):____

By (name and title):____

FINANCIAL POLICY

As our office strives to hold down the cost of patient care, it is important for you to understand your financial responsibility for your medical care. **Our office performs "in office" procedures in which your insurance company considers a surgical procedure.** In some cases **they will apply** "outpatient benefits" in which you may have to meet a deductible or pay an additional co-insurance amount. ***Please check you insurance benefits book for coverage information.***

It is important for you to understand what your insurance policy covers and does not cover. Each patient's insurance policy is different and because of this, it is impossible for our staff to know the details of what your policy covers, does not cover, what is applied to deductible, and so forth*. If you have questions regarding your insurance, please call the member services department listed on your insurance card.*

MANAGED CARE PATIENTS: It is your responsibility to obtain all necessary referrals and/or authorization from your Primary Care Physician. You will not be seen without a current valid referral.
All co-payments are due at the time of service. Failure to pay your co-payment could result in the termination of your insurance by your insurance company.

COMMERCIAL INSURANCE PATIENTS: We will be happy to file your medical services to your insurance company as a courtesy to you. However, you are fully responsible for all charges incurred. Please note your insurance may have their own "Usual, Customary, and Reasonable (UCR)" fee schedule. This is your insurance company's fee schedule and we are not obligated to adjust our fees to match their UCR fees.

SELF-PAY PATIENTS: You are responsible for payment of services on the day you are seen.

WORKER'S COMPENSATION: You are responsible for assisting us in obtaining authorization from your case manager or adjuster for all office visits. We will bill your employer or worker's compensation insurance plan. You are only responsible for payment if your claim is controverted.

MEDICARE PATIENTS: We are participating with Medicare. We will bill Medicare for you. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance after Medicare pays.

STATE ASSISTED PATIENTS: We participate with the Georgia State Medicaid program and will bill Medicaid. Medicaid benefits are valid month to month; therefore, it will be necessary to present your Medicaid certificate to us each month. We will collect all co-payments at the time of service. Please note, if there is a lapse in your monthly Medicaid coverage (i.e. you are not eligible for Medicaid benefits) you will be considered a Self Pay patient.

PAYMENT POLICY

All co-payments, coinsurance amounts, deductibles and/or other patient due balances must be paid in full at the time of your visit. Failure to make payment on your account **will result in your dismissal** from the practice and your account will be turned over to an outside collection agency for payment**. We report unpaid accounts to the credit bureau.** Please note we have a $30.00 returned check on all checks returned to us from our bank for non-sufficient funds which will be charged to your patient account and responsible to pay.

Payment arrangements can be made through our financing company, Care Credit Services. The patient and/or legal guardian is responsible to make payment directly to Care Credit Services per their terms and conditions.

I, ____, understand and agree to the terms as outlined above.

____ Date: __________________
Signature Patient and/or Legal Guardian