Orange County Ear, Nose and Throat Associates

Patient Intake Forms

Patient Information (Acct# «PNumber»)

Please review information below and complete empty boxes.

First Name: Middle Initial: Last Name: **Alias:**			
Sex:	DOB:	Age:	SSN:
Address: Apt City: State: Zip Code:			
Primary Phone:	Work Phone:	Secondary Phone:	
Is it okay to leave a detailed message at the above numbers? YES NO			
Email:		Primary Language:	
Referring Doctor:	Primary Care Provider:		
Marital Status:	Employment: Full Time Part Time Retired Self Employed None	Student Status: Full Time Part Time None	

Guarantor Information

Person responsible for the bill after insurance pays. If the patient is a minor this section must be filled out. If the guarantor is the patient you may skip this section.

Name:		Patient's relationship to guarantor:	
Address: City: State: Zip Code:			
Primary Phone:	Secondary Phone:	Email:	
Guarantor Sex:	**Guarantor DOB:**	Guarantor SSN:	

Emergency Contact Information

A contact person with phone numbers other than patient's phone numbers.

Name:		Relationship to Patient:
Primary Phone:	Work Phone:	Secondary Phone:

Insurance Information

Primary Insurance Carrier:		
Subscriber Name:	**Subscriber Date of Birth:**	Subscriber SSN:
Secondary Insurance Carrier: **«PL2CarrName»**		
Subscriber Name:	Subscriber Date of Birth:	Subscriber SSN:

Authorized Contacts

Please list all person(s) below that you will allow Orange County Ear, Nose Throat Assoc. to share medical and/or financial information, such as a spouse, caregiver, or other family member.

Name	Relationship	Phone Number	Medical Information	Financial Information

Pharmacy Name: _____

Pharmacy Location (City & Cross Streets):_____

How did you hear about us? _____

It is your responsibility to provide Orange County Ear, Nose and Throat Assoc. with proof of insurance and an authorization or referral when applicable. As a courtesy to you, we will bill your insurance carrier(s) on your behalf. The contract between Orange County Ear, Nose and Throat Assoc. and your health plan, as well as the contract between you and your health plan requires that you make payment in full for all copayments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract. Should there be a default on patient responsibility **our office utilizes collection agencies** to further collect on unpaid balances over **120 days past due**.

*****PLEASE READ***Financial Agreement**

In order to properly evaluate our patients, it is often necessary for the physician to perform an in-office procedure such as, but not limited to:

fiberoptic laryngoscopy	*cerumen removal*	*nasal cauterization*
fiberoptic nasal endoscopy	*biopsies*	*foreign body removal*

These services are billed as an **additional charge** from the office visit and additional coinsurance and/or deductible amounts may apply. Although these services are done in the office they are labeled as **"surgery"** on your insurance explanation of benefits. If you have questions regarding the necessity of any of these services, please direct them to your physician at the time of service. PLEASE INTIAL THAT YOU HAVE READ AND UNDERSTAND THE ABOVE:_____

Assignment of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Orange County Ear Nose and Throat Assoc. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all medical and financial information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. This agreement is valid from today's date and remains in effect until I, the patient, revoke this agreement. Everything above is true and correct to the best of my knowledge.

Signature of Patient/Guarantor _____**Date**_____

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the **Notice of Privacy Practices** being adhered to by Orange County Ear, Nose and Throat Assoc. The Notice of Privacy Practices is supplied in accordance with the Privacy rule that is an integral part of the Health Insurance Portability and Accountability act (HIPPA) of 1996.

_____ _____
Signature Date

_____ _____
Patient Name (Please print) Relationship to Patient

Medical History

Please describe the reason for this visit:

Weight:	Height:

Review of Symptoms- PAST 30 DAYS Please check those that apply:

○**Eyes**
- _ Change in vision
- _ Pain
- _ Blurred or double vision
- _ Glaucoma

○ **Respiratory**
- _ Cough
- _ Spitting up blood
- _ Wheezing

○ **Ear / Nose / Throat**
- _ Hearing loss
- _ Hearing noises in your ear(s)
- _ Ear aches or drainage
- _ Nosebleeds
- _ Trouble swallowing
- _ Sinusitis
- _ Sore throat
- _ Snoring
- _ Voice Changes
- _ Oral bleeding
- _ Difficulty and / or pain swallowing

○ **Cardiovascular**
- _ Chest Pain
- _ Palpitations
- _ Shortness of breath
- _ Swelling of limbs

○ **Neurological**
- _ Headaches
- _ Numbness or tingling sensations
- _ Tremors
- _ Head Injury
- _ Fainting or loss of consciousness
- _ Dizziness

○ **Constitutional Symptoms**
- _ Fevers, Chills or Night Sweats
- _ Recent Weight Change
- _ Skin Problems

○ **Gastrointestinal**
- _ Abdominal pain or heartburn
- _ Nausea or vomiting
- _ Problems with bowel movements
- _ Rectal bleeding or blood in stool

○ **Hematological / Lymphatic**
- _ Slow to heal after a cut
- _ Bleeding or bruising tendency

○ **Other Symptoms**
- _ Memory loss or confusion
- _ Depression
- _ Nervousness
- _ Anxiety
- _ Insomnia

Past Medical History Have you ever had the following:

Diabetes	YES	NO	Cancer	YES	NO	Hepatitis A B or C	YES	NO
Stroke	YES	NO	AIDS or HIV+	YES	NO	Bleeding Disorder	YES	NO
Hypertension	YES	NO	Asthma	YES	NO	Sleep Apnea	YES	NO
Heart Condition	YES	NO	Emphysema	YES	NO	Epilepsy	YES	NO
Thyroid Problems	YES	NO	High Cholesterol	YES	NO	Depression	YES	NO
If yes please explain:								
Others:								

Past Surgical History Please list any previous surgeries or major illnesses and include dates:

Surgery			Surgery Date (month/year)
Have you had anesthesia complications?	NO	Yes, please explain:	

Medications If you have not provided office with a list of current medications, please list below:

Blood Thinners

Are you taking any medication or products that can cause thinning of the blood, if yes please circle those below that apply?				
Coumadin	Herbal Supplements	Aspirin	Garlic Supplements	Vitamin E
Ginkgo Biloba	Ibuprofen	Advil	Motrin	Fish Oil
List others:				

Allergies

Are you allergic to the following:
Iodine YES NO **Latex** YES NO **Laundry Detergent(s)** YES NO

Please list any medication and/or food allergies:

Family Medical History ○ Check if there is no family history or history is unknown.

Family Member	***Example: arthritis, cancer, diabetes, etc.***
Mother	
Father	
Sister	
Brother	
Daughter	
Son	

Social History & Additional Information

Race: ○ American Indian ○ Asian ○ Caucasian ○ African American ○ Pacific Islander ○ Other Pacific Islander ○ Alaska Native ○ More than one race ○Refuse to report		
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Undefined ○ Refuse to Report		
Cigarette Smoker: YES NO	If yes, how many packs per day:	If former smoker, date quit:
Alcohol Consumption: YES NO	If yes, amount, type & frequency:	Sobriety date: