ENT & FACIAL PLASTIC™ SURGERY SPECIALISTS OF SHADY GROVE

Medical History Form

Patient Name: _____ Date of Birth: _____

EARS

Ear Pain	○ Yes	○ No
Ear Pressure	○ Yes	○ No
Ear Itchiness	○ Yes	○ No
Dizziness	○ Yes	○ No
Ringing in Ears	○ Yes	○ No
Discharge	○ Yes	○ No
Noise Exposure	○ Yes	○ No
Hearing Loss	○ Yes	○ No
Lightheadedness	○ Yes	○ No

NOSE

Injury	○ Yes	○ No
Surgery	○ Yes	○ No
Blockage	○ Yes	○ No
Headache	○ Yes	○ No
Post Nasal Drip	○ Yes	○ No
Discharge	○ Yes	○ No
Bleeding	○ Yes	○ No
Snoring	○ Yes	○ No
Unable to Smell	○ Yes	○ No
Sinusitis	○ Yes	○ No
Sleep Apnea	○ Yes	○ No
Using CPAP?	○ Yes	○ No

THROAT

Soreness	○ Yes	○ No
Difficulty Swallowing	○ Yes	○ No
Painful Swallowing	○ Yes	○ No
Lump in Throat	○ Yes	○ No
Hoarseness/Change in Voice	○ Yes	○ No
Throat Clearing	○ Yes	○ No

ALLERGY

Hayfever	○ Yes	○ No
Asthma	○ Yes	○ No
Skin Test	○ Yes	○ No
Allergy Shots	○ Yes	○ No

EYES

Watery Eyes	○ Yes	○ No
Blind Spots	○ Yes	○ No
Light Sensitive	○ Yes	○ No
Blurry/Visual Los	○ Yes	○ No
Glasses/Contacts	○ Yes	○ No
Cataracts	○ Yes	○ No
Dry Eyes	○ Yes	○ No

CARDIOLOGY

Chest Pain	○ Yes	○ No
High Blood Pressure	○ Yes	○ No

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RESPIRATORY

Cough	○ Yes	○ No
Pneumonia	○ Yes	○ No
Shortness of Breath	○ Yes	○ No

NEUROLOGY

Stroke	○ Yes	○ No
Weakness	○ Yes	○ No
Headache	○ Yes	○ No
Seizures	○ Yes	○ No

HEMATOLOGY/LYMPH

Bruising	○ Yes	○ No
Bleeding	○ Yes	○ No
Plavix usage?	○ Yes	○ No
Coumadin usage?	○ Yes	○ No
Aspirin usage?	○ Yes	○ No
NSAID usage?	○ Yes	○ No
Clotting problems	○ Yes	○ No

CONSTITUTIONAL

Fever	○ Yes	○ No
Weight Loss	○ Yes	○ No
Fatigue	○ Yes	○ No

GASTROENTEROLOGY

Constipation	○ Yes	○ No
Nausea	○ Yes	○ No
Abdominal Pain	○ Yes	○ No
Heartburn	○ Yes	○ No
Blood in Stool	○ Yes	○ No
Regurgitation	○ Yes	○ No
Vomiting	○ Yes	○ No
Diarrhea	○ Yes	○ No

MUSCULOSKELETAL

Aches	○ Yes	○ No
Weakness	○ Yes	○ No
Arthritis	○ Yes	○ No

FAMILY HISTORY

FATHER	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
MOTHER	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
SIBLINGS	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes
CHILDREN	○ None	○ Allergies	○ Asthma	○ Bleeding Disorders	○ Cancer
	○ Hearing Loss	○ Heart Disease		○ High Blood Pressure	○ Diabetes

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SOCIAL HISTORY

Martial Status:	○ Married	○ Single	○ Divorced	○ Widowed
Occupation:	○ Full time	○ Part time	○ Retired	○ Homemaker
	○ Student	○ Unemployed		
Smoking:	○ Yes	○ No	○ Trying to Quit	
Alcohol:	○ Yes	○ No	○ Social drinker	
	○ Trying to Quit	○ Recovering Alcoholic		
Recreational Drugs:	○ Yes	○ No		
HIV Infected:	○ Yes	○ No	○ Status Unknown	

MEDICAL HISTORY

(Please **CIRCLE** any of the conditions that may relate to you **currently**)

Diabetic	Hyperthyroidism	Asthma	High Blood Pressure
Cardiac Patient	Hypothyroidism	Breastfeeding	Antibiotics Prior To Dental
MAO Inhibitor	Renal Failure	Pregnant	
Recent Mono	Anticoagulants	Liver Disease	

Other Medical History: _____ Cancer: _____

ALLERGIES

Allergies To Medications: _____

☐ No Known Drug Allergies

LIST ALL CURRENT MEDICATIONS:

_____

_____

_____

LIST ALL PAST SURGERIES:

_____

_____

_____

ENT & FACIAL PLASTIC SURGERY SPECIALISTS
OF SHADY GROVE

PATIENT'S NAME (PLEASE PRINT) First, Middle, Last	SOCIAL SECURITY NUMBER	MARITAL STATUS	SEX	DATE OF BIRTH	AGE

HOME ADDRESS CITY, STATE, ZIP CODE	PRIMARY PHONE: SECONDARY PHONE:

RACE: American Indian/Alaska Native Indian ( ) Black-African American ( ) Asian ( ) White ( ) Native Hawaiin or other Pacific Islander ( ) Other Race ( )	ETHNICITY: Hispanic or Latin ( ) Not Hispanic ( )	LANGUAGE: English ( ) Spanish ( ) Other ( ) __

EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE	CELL PHONE	BUSINESS PHONE

REFERRING PHYSICIAN	PRIMARY PHYSICIAN

PHARMACY NAME AND LOCATION

PATIENT EMAIL ADDRESS:

PRIMARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE EXT

SECONDARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE EXT

WERE YOU INJURED ON THE JOB? YES ☐ NO ☐	DATE OF INJURY	WORKMAN'S COMP CLAIM #	NAME, ADDRESS & PHONE OF LIABILITY INS.

ACCIDENT? YES ☐ NO ☐	AUTO ACCIDENT? STATE YES ☐ NO ☐	DATE OF ACCIDENT	NAME, ADDRESS, & PHONE OF ATTORNEY

How did you hear about us?

( ) Providers or Referral
( ) Friends or Family
( ) Internet
( ) Other _____

ENT & FACIAL PLASTIC SURGERY SPECIALISTS
OF SHADY GROVE

INSURANCE AUTHORIZATION, ASSIGNMENT & OFFICE POLICIES

I request that payment of authorized insurance benefits be made on my behalf directly to Ear, Nose & Throat Specialists of Shady Grove, P.C. and I authorize them to release to that company any information necessary to determine benefits for services rendered. I understand that I am responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

AND/OR I request that payment of authorized Medicare benefits be made on my behalf directly to Ear, Nose & Throat Specialists of Shady Grove, P.C. and authorize them to release to the Health Care Financing Administration and its agents any information necessary to determine benefits for services rendered. I understand that I am responsible for charges not covered by this authorization.

I understand that if I may be charged $50.00 for not keeping a scheduled appointment or failing to give a 24 hour notice. I understand that there is a charge of $35.00 for returned checks.

I understand that if my Insurance requires me to have a referral, I am responsible for providing a referral at the time of my appointment. If I do not provide a referral, I understand that I will be considered a "Self Pay" and will be responsible for any charges for my appointment at the time of checking out.

I understand that if I have not met my deductible, I will be responsible for payment of any charges for my visit at the fee scheduled rate of my insurance at the time of my visit.

This information is accurate and true to the best of my knowledge. I understand that I am ultimately responsible to pay for services rendered. I understand that I am responsible for charges not covered by this authorization, including reasonable attorney's fees and costs of collection in the event of default.

As a courtesy, we want to remind you that your insurance policy may have a separate deductible and/or coinsurance for certain in- office procedures which may be listed as surgery on your explanation of benefits (EOB), or hearing related testing.
I understand that if this applies to my insurance policy I will be responsible for these charges.

By signing below, I am acknowledging that I have reviewed and updated all personal information and Insurance information. I understand that this review is required annually.

X_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

ENT & FACIAL PLASTIC SURGERY SPECIALISTS™
OF SHADY GROVE

Release of Confidential Information

I, _____hereby give my consent to

NAME OF PATIENT OR AUTHORIZED AGENT

ENT & Facial Plastic Surgery Specialists of Shady Grove, to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that ENT & Facial Plastic Surgery Specialists of Shady Grove has reserved the right to change its privacy practices, and that a copy of any revised Notice will be available to me upon written request.

I authorize the physicians and staff of ENT & Facial Plastic Surgery Specialists of Shady Grove to contact me regarding my treatment in the following manner:

Leave a detailed message with the type of test(s) performed, test results and/or any other comments related to my health at:

(_____)_____(this is my ☐ cell ☐ home number ☐ work number)

I authorize release of information pertaining to my health care, test results, procedures and billing information to the following person(s) or agencies (if any):

____ Spouse ____Parents____None ____ other (please specify):_____

Name and phone number: _____

I understand that this consent will be actively enforced and that if I wish to change the status of this form, I must do so in person and in writing.

Signed: _____Date: _____

If not the patient, please specify relationship to the patient: _____

☐ Patient refused to sign. Witnessed by:_____

ENT & FACIAL PLASTIC SURGERY SPECIALISTS OF SHADY GROVE

NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 101-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI) affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2003, every patient must receive our new Privacy Notice and execute a new Consent Agreement.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: any information, whether oral or recorded in any medium, that is either created or received by a health provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

Our office will use or disclose your PHI for purposes for treatment, payment and other health care purposes as required, to provide you the best quality health care services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration for the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-health care related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any consent Agreement or Authorization at any time, and all use and disclosure and administration of related health care services will be revised accordingly, with the exception of matters already in process as a result of prior use of the PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed. If you had a "personal representative" initiate an Authorization, you may revoke that authorization at any time

You, the patient, have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information, The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, The Privacy Standard permits, but does not require covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations, however, The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgment to decide whether to disclose any information, reflecting our own policies and ethical principles.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implanted policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.