Patient's Last Name_____ First Name_____Middle Initial_____

SSN_____ Date of Birth_____ Age_____ Sex: Female Male

Address_____ Apartment #_____ City_____

State_____ Zip_____ County_____ Race_____ Language _____

Name & Address of Primary Care (Family) Physician/Pediatrician _____

Referring Physician Name and Address (If different)_____

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone_____ Day Phone _____ Cell Phone_____

Email Address_____

Employer_____ Employer Address_____

What is your occupation?_____ Retired? O Yes O No

Name of Spouse/ Parent / Legal Guardian _____DOB_____ SSN_____

Primary Medical Insurance

Policy Holder Name_____ Policy Holder Social Security #_____Policy Holder DOB_____

Plan Name_____ Policy # _____

Group Name (if applicable)_____ Group Number (if applicable) _____

Ins. Co. Address_____ Ins. Co. Phone Number_____

Secondary Medical Insurance

Policy Holder Name_____ Policy Holder Social Security #_____Policy Holder DOB_____

Plan Name_____ Policy #_____

Group Name (if applicable)_____ Group Number (if applicable) _____

Ins. Co. Address_____ Ins. Co. Phone Number_____

Is this visit covered by workers comp?_____ No fault? _____Claim #_____Date of Injury? _____

If yes, who is your workers comp adjuster and contact?_____ Adjuster's Phone _____

Emergency Contact_____ **Phone #** _____

Provider you are here to see_____ **I will be paying by**: Cash Check Credit Card

I certify this information is true and correct to the best of my knowledge I will notify you of any change in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I have received Georgia Center for ENT's notice of privacy practice.

Responsible Party Signature_____***Date***_____

Patient Name:_____DOB:_____Date:_____

What is the reason you are here today?_____

Allergies? O No Allergies O Do you have latex allergies?

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Circle Yes or No

Have you ever had an allergy test? Yes No

Have you ever taken allergy shots? Yes No

If yes, are you still taking them? Yes No How much relief from shots? O Minimal O Partial O Significant

List all medications you are taking (prescription, over- the-counter or herbal)

O **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address & Phone)_____

Medical surgical history: Have you ever been diagnosed with any of the following?

O **No medical surgical history**

Yes	**Cardiovascular:**	Surgery/Management
O	Coronary Artery Disease	_____
O	Elevated Cholesterol (hyperlipidemia)	_____
O	High Blood Pressure (hypertension)	_____
	Gastrointestinal:	
O	Hepatitis	_____
O	Hernia	_____
O	Gastroesophageal Reflux	_____
	Genitourinary:	
	Prostate enlargement	_____
O	(Benign Prostate Hyperplasia)	_____
O	Kidney Stones (Nephrolithiasis)	_____
O	Renal Failure (acute)	_____
	Ear/Nose/Throat: (HEENT)	
O	Cataracts	_____
O	Glaucoma	_____
O	Chronic ear infection (Otis Media)	_____
O	Hearing Loss	_____
O	Sinus problems (chronic sinusitis)	_____
O	Nasal Polyps	_____
O	Nasal Allergies	_____
O	Recurrent Tonsillitis	_____
O	Tinnitus	_____
O	Vertigo	_____
	Hematologic:	
O	Anemia	_____

Yes	**Immunologic**:	Surgery/Management
O	Allergies Type:_____	_____
O	Food Allergies Type:_____	_____
	Infectious Disease:	
O	Mononucleosis	_____
O	STD Type: _____	_____
	Metabolic/endocrine:	
O	Diabetes Type: _____	_____
O	Thyroid deficiency (hypothyroidism)	_____
O	Thyroid excess (hyperthyroidism)	_____
	Neoplastic:	
O	Cancer Type: _____	_____
	Neurologic:	
O	Migraine	_____
	Obstetric:	
O	Pregnancy Date(s):_____	_____
	Psychiatric:	
O	Adjustment Disorder- Anxiety	_____
O	Major Depression	_____
	Pulmonary:	
O	Asthma	_____
O	COPD	_____
O	Emphysema	_____
O	Sleep Apnea	_____
O	Tuberculosis	_____
O	Do you have a pacemaker? O Yes O No	

If YES to any of the above Diagnosis with surgery performed?

What_____ When/Where_____ By Who_____

Family History of:

ADD/ADHD	O	CVA (Stroke)	O	Learning disability	O
Alcoholism	O	Depression	O	Mental illness	O
Allergies	O	Developmental delay	O	Migraines	O
Alzheimer's Disease	O	Diabetes	O	Obesity	O
Asthma	O	Eczema	O	Osteoarthritis	O
Blood Disease	O	Hearing deficiency	O	Osteoporosis	O
CAD (Coronary Artery Disease)	O	Hyperlipidemia	O	PVD	O
CAD Premature	O	Hypertension	O	Renal Disease	O
Cancer Type: _____	O	Irritable Bowel Syndrome	O	Seizure Disorder	O

Other Family History: _____

Did you consume alcohol? OYes O No O Former Tobacco Use? OYes ONo O Former

Type of Alcohol	Frequency ?	Amt?	Last Drink?	Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
				Cigarettes			
				Other: (List Type)			

Exposed to secondhand smoke? OYes ONo

Caffeine Consumption? OYes ONo Type:_____ Amount Per Day? _____

Review of Systems: Please mark where applicable:

General health problems

Yes No
- O O Fatigue
- O O Fever
- O O Night sweat
- O O Weight loss
- O O Weight gain

Eye Problems

Yes No
- O O Double vision
- O O Itchy eyes
- O O Redness

Ear Problems

Yes No
- O O Drainage
- O O Hearing loss
- O O Infections
- O O Dizziness
- O O Itchiness
- O O Exposure to Excessive Noise
- O O Ear pain
- O O Ringing/ noise in ears

Nose & Sinus Problems

Yes No
- O O Congestion
- O O Facial Pain
- O O Mouth Breathing
- O O Nose Bleeds
- O O Sneezing
- O O Runny Nose
- O O Post Nasal Drainage

Mouth and throat problems

Yes No
- O O Difficulty Swallowing
- O O Sleep Apnea
- O O Snoring
- O O Sore Throat
- O O Hoarseness
- O O Source/Ulcers in Mouth

Heart or circulation problems

Yes No
- O O Heart Murmur
- O O Chest pain
- O O Swelling of Ankles/Edema
- O O Blacking Out
- O O Irregular heartbeat/ Palpitations

Lung or respiratory problems

Yes No
- O O Cough
- O O Shortness of Breath
- O O Wheezing

Musculoskeletal

Yes No
- O O Leg Pain

Stomach problems

Yes No
- O O Abdominal pain
- O O Constipation
- O O Diarrhea
- O O Heartburn
- O O Nausea
- O O Vomiting

Brain or Nervous system problems

Yes No
- O O Headache
- O O Seizures
- O O Focal Weakness
- O O Numbness

Glands or Hormone problems

Yes No
- O O Heat Intolerance
- O O Cold Intolerance
- O O Neck Enlargement/ Goiter

Blood or Lymph Node problems

Yes No
- O O Easy Bleeding
- O O Easy Bruising

Allergy problem

Yes No
- O O Urticaria/ Hives
- O O Food Allergies
- O O Bee Sting Allergies
- O O Environment Allergies

Skin

Yes No
- O O Contact Allergy
- O O Itchy Skin/ Pruritis
- O O Rash
- O O Contact Allergy

Patient Name:_____ DOB: _____

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of your insurance card and photo for your file.

- **Appointments** -A 24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 will then be added to your account.
- **Surgery -** Insurance will be verified including deductible and coinsurance prior to your pre-operative surgical visit. A deposit will be required if insurance benefits are assigned to the doctor due to individual policy deductible and percentage of coverage. Payment in full is required in advance if insurance benefits are not assigned or if no insurance. Any overpayment will be promptly refunded to the patient/guardian or insurance company. Other financial arrangements maybe discuss with our Billing Specialist.
- **Surgery Rescheduling/Cancellation –** Due to frequent re-scheduling and or cancellations of surgeries, it has become necessary to apply an administrative fee for surgery changes. A patient who reschedules or cancels surgery with less than 48 hours' notice for any reason other than a medical condition or death in the immediate family will be charged $150 which will not be applied toward surgical fees and it's nonrefundable.
- **Referrals –** If your plan requires a referral from your primary care physician **it is your responsibility to obtain it prior to your appointment** and have it with you at the time of your visit if you do not have your referral, we will gladly reschedule your appointment for you so that you may obtain it.
- **Co-Payments -** By law we must collect your carrier designated copayment. This payment is expected at the time of service. Please be prepared to pay the copayment at each visit.
- **Self-Pay patients –** For patients who are not using insurance for their office visit, $150 fee will be due at check-in.
- **Medicare –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime signature on file: I request a payment of authorized Medicare benefits be made on my behalf to Georgia Center for ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS and its agents any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **Collection Fees, Bank Fees and Credit Reporting –** Accounts more than 60 days old are subject to a monthly administrative fee not to exceed $10 per month. Accounts 90 days old are subject to being sent to an outside collection agency and reporting to the credit bureau. In addition, banks charge a fee for checks that do not clear or cannot be cashed. You agreed to be liable for all such fees with a minimum charge of $35.
- **Insurance Claims –** If applicable we will submit claims to your insurance carrier. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurance company carrier does not make that payment prompt, you will guarantee payment for all charges herein occurred. In the event your insurer sends payment for a claim from our office to you directly, you agreed to endorse the payment to our practice in full for any amount due within 10 days of postmark.
- **Divorced Separated Parents of Minor Patients-** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Georgia Center for ENT will not be involved with the separation or divorce disputes.

I have read and understand the above terms and conditions and by my signature below, I attest that I fully understand each item and agree to the terms above.

Patient's/ Guardian's Signature:_____ Date:_____

Patient Consent for Use of Email Communication

To better serve our patients, Georgia Center for ENT allows patients to communicate with the staff via email. Prior to doing this, you must read through and find the email policy. Email should only be used for routine matters that do not require an immediate response. **Should you require urgent or immediate attention, email is not appropriate.** We strive to respond to all email communication within two business days if a response is not received within the expected timeframe, please call our office for media assistance.

When communicating via email, **please put the purpose of your message in the subject line** so that we may process it more efficiently. **Also, be sure to include your name, date of birth, and return phone number in the body of your message.** We also ask that you would acknowledge receipt of emails coming from our office. All email communications related to your health and treatment may be filed in your medical record. Georgia Center for ENT is not liable for improper disclosure of information or breaches of confidentiality caused by the patient (i.e. printing or forwarding emails), third parties or technical factors beyond the practices control. In addition, Georgia Center for ENT has no control over the security or management of third-party email systems, if used. The patient understands and agrees that Georgia Center for ENT will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee the unencrypted information will not be intercepted, altered, or read by an unintended recipient.

Email is not appropriate for certain types of doctor-patient communication. Specifically, email is useful for fairly simple, non- urgent questions. One example of an appropriate email question is asking if an over-the-counter medicine is OK to take with your prescription medications. Another example is asking about a news story that seems to say one of your medications is dangerous. For standard medication refill request, you will get a faster response if you have your pharmacy fax a refill request to the office. The Dr. Fletcher has the exclusive right to decide what is and is not appropriate for Email. If it is determined that your question is not appropriate for email, you will be informed and may need to schedule an appointment in order to discuss your question with the Dr. Fletcher.

I understand that Georgia Center for ENT is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond the practices control. I understand and agree to the above email policy. By signing below, I am agreeing that Georgia Center for ENT may send medical related correspondence to me via email, and may respond to my emails via email.

Signed _____

Patient's Name _____ Date _____

HIPPA Release Form

Name: _____**Date of Birth**: _____/_____/_____

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Children _____

( ) Other _____

( ) Information is not to be released to anyone.

This **Release of Information** will remain in effect until termination by me in writing.

Please Call ( ) My Home ( ) My Work ( ) My Cell Number: _____

If unable reach me:

( ) You may leave a detailed message

( ) Please leave a message asking for me to return your call

( )_____

The best time to reach me is (day) _____between (time) _____

Signed: _____Date:_____/_____/_____

Witness: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I, _____ acknowledge that **Georgia Center for ENT and Facial Plastics**, has made their Notice of Privacy Practices available for my view in the waiting room. This notice describes how **Georgia Center for ENT and Facial Plastic**, may use and disclose my (or my child's) healthcare information. Certain restrictions on the use and disclosure of my (or my child's) healthcare information, and my rights that I may have regarding my (or my child's) protected health information.

_____

Signature

_____

Relationship to Patient