EAR, NOSE, THROAT – HEAD & NECK SURGERY OF HUNTSVILLE, P.C.
201 Whitesport Drive, Huntsville, AL 35801
Phone (256) 881-5353 Fax (256) 881-0712
www.entofhuntsville.com

Mark L. Hagood, M.D. Shane P. Davis, M.D. Benjamin D. Powell, M.D. J. Stephen Brigance, M.D.

DATE _____

PLEASE PRINT & FILL IN INFORMATION COMPLETELY

PATIENT _____
FIRST MIDDLE LAST

SEX Male / Female **MARITAL STATUS** Married / Single / Divorced / Widowed **AGE** _____ **DOB** _____

RACE _____ **PRIMARY LANGUAGE** _____ **HISPANIC / NOT HISPANIC**

HOME PH (_____) _____ **WORK PH** (_____) _____ **CELL PH** (_____) _____

EMAIL ADDRESS _____

HOME ADDRESS_____
APT# STREET #

_____
CITY STATE ZIP

DRIVERS LICENSE # _____ **ISSUING STATE** _____

RESPONSIBLE PARTY (IF PATIENT IS A CHILD) _____

PATIENT (OR RESPONSIBLE PARTY) EMPLOYED BY _____

OCCUPATION _____

PATIENT SSN _____

DO YOU HAVE MEDICAL INSURANCE? YES / NO (IF YES, PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST)

NAME OF PRIMARY INSURANCE COMPANY _____

MEMBER/CONTRACT/ID # _____ **GROUP #** _____

SUBSCRIBER'S NAME / DOB _____ / _____ **EMPLOYER** _____

RELATIONSHIP TO PATIENT _____

NAME OF SECONDARY INSURANCE COMPANY _____

MEMBER/CONTRACT/ID # _____ **GROUP #** _____

SUBSCRIBER'S NAME / DOB _____ / _____ **EMPLOYER** _____

RELATIONSHIP TO PATIENT _____

EMERGENCY INFORMATION: ***NAME AND PHONE NUMBER(S) OF A RELATIVE OR FRIEND (PLEASE LIST ON FAMILY HIPPA AS WELL)***

_____

REFERRING OR PRIMARY DOCTOR _____

ADDRESS _____

_____

PHONE ( ) _____

Specialty: Internal Medicine
Family Practice
Pediatrician
Other: _____

STATEMENT OF RESPONSIBILITY

I ACCEPT RESPONSIBILITY OF PAYMENT FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. SHOULD ANY PART OF THIS BILL BECOME DELINQUENT, I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES, WHICH MAY BE BASEDON A PERCENTAGE AT A MAXIUM OF 50% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCULDING REASONABLE ATTORNEY'S FEES, INCURRED.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: X _____

***PLEASE TURN PAGE AND FILL IN HEALTH HISTORY**

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PATIENT'S NAME: _____ AGE: _____ TODAY'S DATE: _____

REASON FOR APPOINTMENT TODAY: _____

_____

DURATION OF PROBLEM: _____

HEALTH HISTORY

Have you had the following medical problems? (Please Circle):

Bleeding / Blood Disorder	Heart Disease	Liver Disease	Other_____
Cancer (type _____)	High Blood Pressure	Lung Disease	_____
Diabetes	Kidney Disease	Thyroid Disorder	_____

OVER-THE-COUNTER MEDICATIONS (PLEASE CIRCLE): Aspirin, Ibuprofen, Naproxen, Claritin, Zyrtec, Other: _____

PRESCRIPTION MEDICATIONS (INCLUDING NASAL SPRAYS): NONE

Name	Dosage	Frequency	SURGERIES:	DATE:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ALLERGIES TO MEDICATIONS (Please Circle): NONE Penicillins Sulfa Drugs Latex

Other: _____

Are you currently pregnant? Yes / No If yes, _____ weeks

Have you ever smoked? Yes / No If yes, _____ packs per day for _____ months / years.

When did you quit? _____

Are you exposed to second-hand smoke? Yes / No

Do you drink alcohol? Yes / No Occasionally Socially Regularly

FAMILY HISTORY OF MAJOR MEDICAL ISSUES (PARENTS AND / OR SIBLINGS) **(Please Circle):**

Cancer Diabetes Stroke High Blood Pressure Bleeding Disorders High Cholesterol Heart Disease Other: _____

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PATIENT'S NAME: _____ AGE: _____ TODAY'S DATE: _____

REVIEW OF SYSTEMS

Circle any illnesses, problems, or symptoms which apply to you:

CONSTITUTIONAL SYMPTOMS

Good general health lately
Recent weight change
Loss of appetite
Fatigue

EYES

Eye disease or injury
Blurred or double vision
Glaucoma

EARS / NOSE / MOUTH / THROAT

Hearing loss
Ringing in the ears
Ear aches or drainage
Nosebleeds
Trouble swallowing
Bleeding gums
Sore throat
Snoring
Voice changes
Nasal congestion
Nasal discharge (clear / yellow / green)

MUSCULOSKELETAL

Joint pain / Stiffness
Muscle pain / Cramps / Weakness
Back pain

CARDIOVASCULAR

Chest pain or angina
Palpitations
Shortness of breath walking or lying flat
Swelling of feet, ankles or hands
Murmur

RESPIRATORY

Cough
Spitting up blood
Shortness of breath
Wheezing

GASTROINTESTINAL

Problems with bowel movements
Nausea or vomiting
Rectal bleeding or blood in stool
Abdominal pain or heartburn

GENITOURINARY

Flank pain
Difficulty with urination
Kidney stone

NEUROLOGICAL

Headaches
Numbness or tingling sensations
Tremors
Head injury
Dizziness

PSYCHIATRIC

Memory loss or confusion
Nervousness
Depression
Insomnia

HEMATOLOGIC / LYMPHATIC

Bleeding or bruising tendency
Phlebitis / Blood clots
Past transfusion

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Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by **ENT-HNS of Huntsville, P.C.** or disclosed to others for the purposes of treatments, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES

ENT-HNS of Huntsville, P.C. is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, **ENT-HNS of Huntsville, P.C.** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or **Rebecca Riggs, CEO,** if you would like additional information or clarification.

It is a violation of the federal privacy standards if **ENT-HNS of Huntsville, P.C.** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy brochure, please consult with a practice representative or **Rebecca Riggs, CEO,** at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, **ENT-HNS of Huntsville, P.C.** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

ENT-HNS of Huntsville, P.C. reserves the right to change or modify the privacy practices outlined in the Notice of Privacy brochure. **ENT-HNS of Huntsville, P.C.** will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **ENT-HNS of Huntsville, P.C.** to use and disclose my health information in accordance with this consent and the notice provided.

_____
Name of Patient (Please Print)

_____
Signature of Patient / Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Ear, Nose, Throat – Head & Neck Surgery of Huntsville, P.C.** to release to my insurers full information, including copies of records and operative notes relative to my illness.

SIGNATURE OF PATIENT OR GUARDIAN: _____

DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS

Insurance will only be filed for surgery or office procedures unless your insurance plan is one in which **Ear, Nose, Throat – Head & Neck Surgery of Huntsville, P.C.** is a participating provider. Insurance will be filed for all services rendered to patients insured by such plans. The assignment of benefits only applies to insurance filed by this office.

I hereby authorize payment to be made directly to **Ear, Nose, Throat – Head & Neck Surgery of Huntsville, P.C.** provider of services filed for. I understand that I am financially responsible for charges not covered by this assignment of benefits. **I FURTHER UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT HONOR THIS ASSIGNMENT OF BENEFITS AND PAYS ME DIRECTLY FOR SERVICES RENDERED, I WILL FORWARD THE INSURANCE CHECK OR MY PERSONAL CHECK IN THE SAME AMOUNT TO THE ABOVE ADDRESS WITHIN SEVEN (7) DAYS OF RECEIPT OF THE INSURANCE CHECK.**

SIGNATURE OF PATIENT OR GUARDIAN: _____

DATE: _____

*A COPY OF THIS SIGNATURE SHALL BE AS VALID AS THE ORIGINAL

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Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:
Health Information this practice collects or receives about you may be disclosed to the following persons:

_____ _____
Name of Person / Relationship to Patient Name of Person / Relationship to Patient

_____ _____
Name of Person / Relationship to Patient Name of Person / Relationship to Patient

Use and Disclosure of Information:
_____ I ***authorize*** the person(s) listed above to receive <u>all health information</u> about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at ENT-HNS of Huntsville, P.C.

_____ I ***do not authorize*** the following information to be disclosed to any other parties except to me as the patient (Please specify):

Expiration Date of Authorization
This authorization will expire upon the minor's age of majority (19 years old) or upon termination or update by the patient or the patient's personal representative or guardian.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to ENT-HNS of Huntsville, P.C. You should contact the office manager or other authorized representative to terminate this authorization.

Potential for Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

SIGNATURE

_____
Name of Patient (Please Print)

_____
Signature of Patient / Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient