EAR, NOSE, THROAT & FACIAL PLASTIC SURGERY, P.A.

Today's Date________________

PATIENT REGISTRATION

PATIENT

Social Security #____________________ Preferred Name (Nickname)____________________

First Name____________________ Middle Name______________ Last Name______________

Mailing Address____________________ City____________ State________ Zip Code__________

Sex__________ Date of Birth______________ Marital Status__________ Race (optional)__________

Ethnicity (optional)____________ Employer______________________________

Email______________ Phone: Home__________ Work__________ Cell__________

Spouse's Name______________________________ Phone__________

Address______________________________ Date of Birth__________

Employer______________ Phone______________ Social Security #______________

REFERING DOCTOR______________________________

EMERGENCY INFORMATION**Name of someone NOT LIVING with you**

Name______________ Relation______________ Phone______________

PARENT/LEGAL GUARDIAN**Only fill out parents if patient is a minor or student**

Mother/Legal Guardian______________________________ Phone__________

Address______________________________ Date of Birth__________

Employer______________ Work Phone______________ Social Security #______________

Father/Legal Guardian______________________________ Phone__________

Address______________________________ Date of Birth__________

Employer______________ Work Phone______________ Social Security #______________

PREFERRED PHARMACY______________________________

INSURANCE INFORMATION

Cardholder Name (Subscriber)____________________ Relationship to patient______________

PLEASE COMPLETE SECTION BELOW FOR WORKMEN'S COMPENSATION

Date of Injury____________________

Whom should we contact to verify workmen's comp?______________ Phone______________

PATIENT INFORMATION FORM
Ear, Nose, Throat & Facial Plastic Surgery, P.A.
Head & Neck Surgery Center, LLC

Payment

CLINIC POLICY: I authorize the Physicians of Ear, Nose, Throat and Facial Plastic Surgery, P.A. and Head and Neck Surgery Center, LLC and its designees to provide treatment and use my health information for treatment, and healthcare operations (TPO), which includes submitting information to any insurance company for the purpose of processing claims. I further authorize any outside laboratory, radiology centers, Pathologist and Radiologist who may interpret and/or report on diagnostic test ordered by ENT-FPS and HNSC and use my health information for billing and payment. I understand that if any account should ever require action by a collection agency or attorney in order to collect the balance owed, fee charged by these agents may e added to my balance due on my account. I further understand that in the event of a returned check for ISF/Account Closed, etc. that a $30.00 fee will be assessed. I also understand and agree that if this account goes into default I will be responsible for all court costs, attorney fees and collection fees, which will total 35% of the balance of the account at the time of default.

MEDICARE AND/OR MEDICAID: I hereby request that the payment of authorized Medicare/Medicaid benefits to me or on my behalf for services furnished to me in or by ENT-FPS or HNSC be made to ENT-FPS or HNSC. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. ***I understand that certain services may not be covered under the Medicare/Medicaid program and that I may be responsible for the entire charge incurred for such services if other third party coverage is available.*** I also understand all deductibles are due unless they have been met within the period specified by Medicare.

Insurance: I hereby assign to ENT-FPS and HNSC all rights, benefits and interest under any insurance polity, health plan, Workers' Compensation or other third party liable to me, in consideration for services rendered by ENT-FPS and HNSC. I hereby authorize payment directly to ENT-FPS for workers compensation coverage for medial expenses for treatment received at ENT-FPS. I hereby authorize payment directly to ENT-FPS of all third party liability insurance coverage, third party payer, health plan and individual liability insurance coverage for medical expenses incurred as a result of an accident, injury or illness for which I received treatment at ENT-FPS or HNSC.

CONSENT TO TREATMENT

The undersigned authorizes the Physicians assigned to furnish medical and/or surgical treatment by those means he/she considers necessary and proper in treatment of the patient identified below while a patient of ENT-FPS and HNSC. Should additional treatment requiring diagnostics including but not limited to CT scans, laboratory tests and blood drawings for theses tests or services will be explained at that time. An ENT-FPS provider may perform the recommended treatment, but you also have the freedom to choose another provider other than ENT-FPS providers at any time to furnish treatment or to render a second opinion. I have been given the opportunity of ask questions and all such questions asked were answered in language I understand and to my satisfaction.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION/POLICIES AND PROCEDURES/NARCOTIC/CONTROLLED SUBSTANCES CONSENT

I have received and had an opportunity to ask questions concerning ENT-FPS's and HNSC's Notice of Privacy Practices for Protected Health Information. I have and received an opportunity to ask questions concerning ENT-FPS's and HNSC's Narcotic/Controlled substances Informed Consent for Treatment.

HEALTH INFORMATION RELEASE

I hereby grant permission to ENT-FPS and HNSC to discuss my health information with the following people:

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Lifetime signature of patient or responsible party:______________________________ Date:_______________

Relationship to patient, if not patient:______________________________

(If signing on behalf of a minor as parent or legal guardian, the responsible party agrees and acknowledges the foregoing on behalf of the minor and represents that he/she has full power and authority to do so.)

EAR, NOSE, THROAT & FACIAL PLASTIC SURGERY, P.A.

Today's date:______/______/________ **Patient Name:**________________________________

Date of Birth:____________ **Accident/Injury?** ☐ **Yes** ☐ **No** **If yes, date occurred**________________

PATIENT MEDICAL HISTORY: (Please check all that apply)

☐ Diabetes	☐ Sleep Apnea	☐ Problems with Anesthesia
☐ Glaucoma	☐ Stroke	☐ High Blood Pressure
☐ Asthma	☐ Heartburn	☐ Hearing Loss
☐ Migraines	☐ Allergies	☐ Thyroid problems
☐ Sinusitis	☐ Heart Disease	☐ Bleeding Disorder
☐ Cancer	☐ Sickle Cell	☐ Kidney Disease
☐ None of the above	☐ Other ________________	

FAMILY MEDICAL HISTORY: (Please check all that apply to Parents or Brothers/Sisters)

☐ Diabetes	☐ Sleep Apnea	☐ Problems with Anesthesia
☐ Glaucoma	☐ Stroke	☐ High Blood Pressure
☐ Asthma	☐ Heartburn	☐ Hearing Loss
☐ Migraines	☐ Allergies	☐ Thyroid problems
☐ Sinusitis	☐ Heart Disease	☐ Bleeding Disorder
☐ Cancer	☐ Sickle Cell	☐ Kidney Disease
☐ None of the above	☐ Other ________________	

SOCIAL HISTORY: (For patients 13 years and older only)

Do you drink alcoholic beverages: ☐ Yes ☐ No

Do you drink caffeine ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No How many weeks?____________

Do you use tobacco? ☐ Yes ☐ No ☐ Current smoker ☐ Former smoker ☐Never smoked ☐ Chew

SURGICAL HISTORY:

Have you had a previous surgery on your ear, nose, throat, head or neck? ☐ Yes ☐ No

If yes, what type of surgery?________________________________

List any other surgery your have had:

____

____

____

CURRENT MEDICATIONS: (List all medications you currently take, including supplements and over the counter drugs)

Drug Name	Dose	Frequency

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No If yes, please list:

____