Welcome to our practice. The information you provide below will be used to file insurance claims, expedite your care and contact the individuals pertinent to your care. **Please complete all information.** If information does not apply, write N/A. **Please print clearly.**

Patient Information 2018

Last Name:_____ First Name: _____ MI:____

SSN:_____ D.O.B:_____ Sex: _____
Marital Status: S M D W Sep Race: White / Black/ Hispanic / Asian / Other_____

Address:_____
Street City, State Zip Code

Home Phone: (_____)_____-_____ Cell Phone: (_____) _____-_____

Email:_____

How did you hear about our office? Google ___ Facebook ___ Family/Friend ___ Other _____

Patient is: Full Time Student____ Employed____ Part-Time_____ Retired____ Self Employed____
Employer: _____ Work Number: (_____) _____
Occupation_____
Spouse's Name: _____Spouse's SSN:_____ Spouses D.O.B:_____
Can we leave messages at your home? YES NO Can we leave messages at your work? YES NO

Responsible Party Information

(If adult, put SELF and go to next section)

Name: _____ SSN: _____
D.O.B:_____
Relationship to Patient: _____ Home Phone:(____) _____ Work:(____)_____
Address:_____
Street City, State Zip Code
Employer: _____ Occupation:_____ Shift:_____
Military Only: Active_____ Retired_____ Branch of Service_____ Rank_____

Name/Phone number of Emergency Contact:

Name:_____ Relationship_____ Phone Number_____

Patient's Family Doctor:_____ Patient's Referring Doctor_____

Insurance Information

(Primary)
Ins Co Name:_____ Policy #:_____ Group #:_____
Policyholder's Name:_____ Policyholder's D.O.B:_____
Policyholder's SSN:_____ Relationship to Insured:_____
(Secondary)
Ins Co Name:_____ Policy #:_____ Group #:_____
Policyholder's Name:_____ Policyholder's D.O.B:_____
Policyholder's SSN:_____ Relationship to Insured:_____

Date:_____ Chart Number:_____

Patient Name:_____ **Chart Number:** _____ **Date:**_____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

ADDITIONAL **RELATED** SYMPTOMS (***please circle***):

GENERAL: FATIGUE, FEVER, CHILLS, NIGHT SWEATS, WEIGHT LOSS, WEIGHT GAIN

HEAD/NECK: HEADACHES, NECK STIFFNESS, NECK MASS (L / R / MIDLINE)

EYES: CHANGE IN VISION, REDNESS, DRYNESS, BURNING, ITCHY/WATERY

EARS: HEARING LOSS (L / R), RINGING (L / R), ITCHING (L/ R), FULLNESS (L / R), DRAINAGE (L / R), PAIN (L / R), RECURRENT EAR INFECTIONS

NOSE: CONGESTION, RUNNY NOSE, POST NASAL DRIP, SINUS PAIN, SINUS PRESSURE, NOSE BLEEDS (L / R), LOSS OF SMELL, RECURRENT SINUSITIS, SEASONAL ALLERGIES

MOUTH/THROAT: ORAL ULCER / LESION / MASS, SORE TONGUE, DENTAL PAIN, DRY MOUTH, BAD BREATH, SORE THROAT, LUMP IN THROAT, TROUBLE SWALLOWING, HOARSENESS, SNORING, RECURRENT THROAT INFECTIONS

LUNG: SHORTNESS OF BREATH, COUGH (DRY / PRODUCTIVE / CHRONIC), WHEEZING, COUGHING BLOOD

CARDIAC: CHEST PAIN, IRREGULAR HEART BEAT, FAINTING

GI: NAUSEA, VOMITING, CRAMPING, CONSTIPATION, DIARRHEA, HEARTBURN

SKIN: RASH, HIVES, ITCHING, ABSCESS, LESION

NEURO: TINGLING / NUMBNESS, SEIZURE, DEVELOPMENTAL DELAY, DIZZINESS / VERTIGO

MUSCLE/JOINT: JOINT PAIN, MUSCLE CRAMPS

ENDOCRINE: COLD / HOT INTOLERANCE, ENLARGED LYMPH NODES

PSYCH: DEPRESSION, ANXIETY, DIFFICULTY SLEEPING

HEMATOLOGY: EASY BRUISING, FREE BLEEDING, BLOOD CLOTS

MEDICATIONS TRIED FOR **CURRENT PROBLEM (please circle):**

ANTIHISTAMINE: ZYRTEC, ALLEGRA, XYZAL, CLARITIN, BENADRYL, CLARINEX

LEUKOTRIENE: SINGULAIR, ZYFLO

INTRANASAL ANTIHISTAMINE: ASTEPRO, ASTELIN, PATANASE, OMNARIS

NASAL SPRAYS: NASONEX, NASACORT AQ, VERAMYST, RHINOCORT AQ, NASALCROM, AFRIN, NEOSYNEPHRINE, FLONASE

MUCOLYTICS: MUCINEX, NASAL SALINE SPRAY, NEILMED SINUS RINSE

COMBOS: ZYRTEC D, ALLEGRA D, CLARITIN D, CLARINEX D, SUDAFED, TYLENOL SINUS, TYLENOL ALLERGY

ASTHMA: ALBUTEROL, PROVENTIL, VENTOLIN, ADVAIR, ASMANEX, PULMICORT, SPIRIVA, SERAVENT, FLOVENT

ANTIBIOTICS: AMOXICILLIN, AUGMENTIN, AVELOX, BIAXIN, BACTRIM, CLINDAMYCIN, CECLOR, CEFZIL, ERYTHROMYCON, KEFLEX, LORABID, LEVAQUIN, OMNICEF, ROCEPHIN, TETRACYCLINE, VANCOMYCIN, Z-PAK

ORAL STEROIDS: PREDNISONE, MEDROL, ORAPRED

REFLUX MEDS: PRILOSEC/OMEPRAZOLE, NEXIUM, PROTONIX, ACIPHEX, KAPIDEX/DEXILANT, PREVACID, PEPCID/ZANTAC, TAGAMENT

MIGRAINE MEDS: RELPAX, TREXIMET, IMITREX, TOPAMAX, ZATIDOR

EYE DROPS: NASAREL, OPTIVAR, PATADAY, CROMOLYN

EAR DROPS: ACETASOL, AURALGAN, CIPRODEX, CIPRO HC, DERMOTIC OIL, DEBROX, TIROXIN, OFLOXACIN, CLOTRIMAZOLE

OTHER: _____

PAST ***PERSONAL*** MEDICAL HISTORY (***please circle***):

ACID REFLUX, ASTHMA, CANCER: _____ , COPD, DIABETES, HEART MURMUR, HEART ATTACK, HEART FAILURE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, HIV, KIDNEY FAILURE, LIVER DISEASE, SLEEP APNEA, STOMACH ULCER, STROKE, THYROID DISORDER (HYPO / HYPER / NODULES), OTHER_____

PAST ***SURGICAL*** HISTORY (***please list***): _____

_____

_____

Patient Name:_____ **Chart Number:** _____ **Date:**_____

FAMILY MEDICAL HISTORY (***please circle***):

ALLERGIES, ASTHMA, BLEEDING DISORDER, CANCER: _____, DIABETES, HEART DISEASE, HIV, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, THYROID PROBLEMS, OTHER _____

SOCIAL HISTORY:

DO YOU SMOKE / CHEW TOBACCO (Circle which)? → **NO**___ QUIT ____YEARS AGO **YES**_____ : _____ PACKS/DAY x ____YEARS

DO YOU DRINK ALCOHOL? → **NO** _____ **YES** _____ : _____ DRINKS/DAY

DO YOU USE ILLICIT DRUGS? → **NO** _____ **YES** _____ IF SO, WHICH?: _____

ARE YOU OR COULD YOU BE PREGNANT? (females only) **NO** _____ **YES** _____ BREASTFEEDING? **NO** _____ **YES**_____

MEDICATION ALLERGIES?: NO _____ YES _____ Please list:_____

_____

LATEX ALLERGY? NO ____ YES _____ **OTHER ALLERGIES**?: _____

PREFERRED PHARMACY: _____ PHONE:_____

ADDRESS: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (include over the counter medications, herbals, etc.)

☐ I am not currently taking any medications

MEDICATION NAME	DOSAGE/STRENGTH	FREQUENCY	REASON FOR TAKING

Patient Name:_____ **Chart Number:** _____

Hampton Roads Otolaryngology, PLLC (herein referred to as HROA) appreciates the confidence you have shown in choosing us to provide for your healthcare needs. Below are our general policies. Please review this information and sign where indicated.

Patient Financial Policies

I understand that it is my responsibility to provide HROA with current, accurate billing information at the time of check in and to notify HROA of any changes in this information.
I understand that it is my responsibility to pay my co-pay at the time services are rendered. I understand that this is a contractual agreement that I have with my health plan and that HROA also has a contract agreement with my health plan to collect co-pays at the time of service.
I understand that I will be billed for any amounts due by me including co-insurance amounts, co-payments and deductibles and that I have a financial responsibility to pay these amounts.
I understand that insurance claims pending which exceed the agreed upon time limit for payment with respect to the term of my insurance company's contract with my provider are my responsibility.
I understand that if any charges billed to me are still outstanding after 90 days from the date services were rendered, my account may be referred to a collection agency or an attorney for collection, unless other acceptable payment arrangements can be made. I agree to pay all costs of collection, including but not limited to, **thirty five percent collection** agency fees plus attorney fees and court costs. In the event my account is in default, I agree to pay interest at the rate of (18%) per annum from and after the date of treatment. I hereby waive the benefit of my homestead exemption as to this debt.
I understand it is my responsibility to obtain a referral (if required by your insurance company). If this referral is not obtained, then all charges will be the responsibility of the guarantor.
I understand there is a $50.00 fee for any check returned from my bank.
I understand that if I do not cancel an appointment 24 hours prior to my scheduled appointment time, or if I do not show for my appointment, there may be a $50.00 fee. If I cancel/no show three appointments, I may be released from care. If I am released, I will be notified in writing by HROA.
I have read the above policy regarding my financial responsibility to HROA for providing services to me or the above named patient. I authorize my insurer to pay any benefits directly to HROA, the full and entire amount of the bill incurred by me or the above named patient.

_____ _____ _____
Patient / Legal Guardian **PLEASE PRINT** Patient / Legal Guardian **SIGNATURE** Date

Consent for Treatment & Authorization for Release of Information

I hereby authorize HROA through its appropriate personnel, to perform or have performed upon me, or the above named patient appropriate assessment & treatment procedures. Upon assessment by the physician,an endoscope may be used in order to further evaluate the nasal or sinus cavity,which may result in an additional charge determined by your insurance plan.
I understand that in the course of treatment, there is a possibility that HROA healthcare workers may become exposed to my blood or body fluids. State laws require a sample of my blood be tested for the presence of infectious diseases. The results of the tests will be released to me and the healthcare worker that was exposed. I further authorize HROA to release any & all medical information on myself or the above named patient to my insurance company to process my claim and hereby authorize a copy of my medical information be sent to my primary care physician as well as any attending or consulting practitioners.

_____ _____ _____
Patient / Legal Guardian **PLEASE PRINT** Patient / Legal Guardian **SIGNATURE** Date

Acknowledgement of Review of Notice of Privacy Practices And Marketing Option Selection

Patient Name:_____ **Chart #:**_____

I have reviewed the Notice of Privacy Practices for this practice and received a copy for my records, if requested. I consent to release of my Protected Health Information for the purposes of treatment, payment, and healthcare operations (as defined in the Notice). I understand that any release of information beyond these three purposes or any other legally permitted release requires a separate authorization.

_____ _____ _____

Patient / Legal Guardian **PLEASE PRINT** Patient / Legal Guardian **SIGNATURE** Date

We must allow you the opportunity to opt-out of receiving information from our practice regarding treatment options available to you and other services we offer now and in the future. We will never release your information to a third party outside the scope of our Privacy Practices as explained on the Notice. If you do not make a selection and sign below, we will assume that you have consented to receive this information from us. Please make a selection below:

☐ Yes, I would like to receive information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.

☐ No, I do not want information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.

_____ _____ _____

Patient / Legal Guardian **PLEASE PRINT** Patient / Legal Guardian **SIGNATURE** Date

Authorization for Release of Medical Information

I, _____, (patient's name) hereby authorize Hampton Roads Otolaryngology Associates, PLLC to release or discuss any of my medical information with the follow individuals: (We cannot discuss any medical information with other physicians unless noted on your patient information form or listed here)

Please include any friends and family members you may authorize to have access to any of your information

Name **Relationship to Patient**

_____

_____

_____

_____

If you would like to set limitations on what medical information can be released to these individuals please list below what information we may provide. If you would like no limitations set then just write ALL.

_____

_____

_____

***Please note that this authorization will expire in 1 year. If you would like to set a particular expiration date for less than 1 year please specify:**_____

_____ _____ _____

Patient / Legal Guardian SIGNATURE **Relationship to Patient** **Date**