PATIENT INFORMATION

DATE: ___________

Home Phone: (   )________-_________ **Cell Phone: (   )_________-___________**

Last Name: ____________________ **First:** __________________________ **Middle In.** _________ **Sex: M/F**

Age: _____ **Birth Date:** ______/______/________**SSN :(required, unless under 18):**______/________/________

Mailing Address: ____________________________**City:**_______________ **State:**_________ **Zip:** ________

Race: _________ **Language:** ____________ **Ethnicity: Hispanic/Non-Hispanic**

Minor ______ **Married**______ **Single** _______ **Widowed** ________ **Divorced** ______

Full Time Student_____ **Part Time Student** ___________ **School Name:** ____________________________

May we contact you by E-Mail? No _____ **Yes** ____ **E-Mail Address:** ______________________________

How were you referred? Dr.: ___________ **Internet** _____ **Another Patient** ______ **Other** ______________

Employment Information

Retired: ________

Employed By: ____ Phone Number: (   ) ______-_______.

If Married: Spouse's Name: ____

Employed By: ____ Phone Number: (   ) ______-_______

Birth Date: ______/______/_______ Social Security #: ________/________/________

If Patient is a minor: (required) Father's Name: ______________________________________

Employed By: ____ Phone Number: (   ) ______-_______

Birth Date: ______/______/_______ Social Security #: ________/________/________

If Patient is a minor: (required) Mother's Name: ______________________________________

Employed By: ____ Phone Number: (   ) ______-_______

Birth Date: ______/______/_______ Social Security #: ________/________/________

Insurance Information

Do you have medical insurance? Yes ______ No _______

Insurance Company Name: ____

Policy Holder Name: ________________________ ID#:_________________________ Group#: _____________

CONTINUE ON BACK SIDE

Emergency Information

In case of emergency, who should we notify?

Name: ______________________ **Relationship:** ______________________

Phone Number: ________________________________

Physician History

Please list doctors seen in the past 5 years:
Dr. ______________________ **City/State:** ______________________

Dr. ______________________ **City/State:** ______________________

If you have Medicare, please read & sign below:

I request that payment of authorized Medicare benefits be made on my behalf to South Lake Ears, Nose and Throat P.A. for any services furnished to me by their physician(s). I authorize any holder of medical information about me to be released to the HCFA and it's agents if any information is needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

______________________ ______________________

Beneficiary Signature **Date**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Southlake Ears, Nose and Throat to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Southlake Ears, Nose and Throat's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Southlake Ears, Nose and Throat reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Southlake Ears, Nose and Throat at 9710 Sam Furr Rd, Ste.D, Huntersville, NC 28078.

With this consent, Southlake Ears, Nose and Throat, may call my home or other alternative location and leave a message on voicemail or with another person, may mail to my home or other alternative location, or e-mail to my e-mail or alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder calls, appointment reminder cards, patient statements, and insurance items that pertain to my clinical care. I have the right to request that Southlake Ear, Nose and Throat, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing below I am consenting to Southlake Ears, Nose and Throat's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Southlake Ears, Nose and Throat, may decline to provide treatment to me.

______________________ ______________________

Signature of Patient or Legal Guardian **Date**

SOUTH LAKE EARS, NOSE AND THROAT MEDICAL HISTORY

Patient Name: ______________________ **Date of Birth:** ______________________

Past Medical History: Have you ever had the following? (Circle "YES" or "NO" Leave Blank if Uncertain)

Eye Trouble (other than glasses)	YES NO	Trouble with Ears or Nose	YES NO
Hypertension	YES NO	Blood or Plasma Transfusion	YES NO
Heart Disease	YES NO	Bleeding Tendency	YES NO
Stroke	YES NO	Respiratory	YES NO
Gastrointestinal	YES NO	Prostate Disorder	YES NO
Diabetes	YES NO	Kidney Disease	YES NO
Thyroid Disease	YES NO	Mitral Valve Prolapse	YES NO
Hepatitis	YES NO	Cancer	YES NO
HIV/AIDS	YES NO	Anemia	YES NO
Neurological	YES NO	Allergic/Immunologic	YES NO
Muscular/Skeletal	YES NO	Trouble with Mouth or Throat	YES NO

Any Other Disease Please List: ______________________________________

Past Surgical History:	**When:**	**Hospital:**
______________	______________	______________
______________	______________	______________
______________	______________	______________

Patient Social History

Use of Tobacco? Never_____ Daily_____ ________Packs/Day How Long? ______Yrs

Use of Alcohol? Never_____ Rarely_____ Moderate ______ Daily______ Number or drinks per day? _____

Use of Drugs? Never_____ Rarely______ Moderate_______ Daily_____ Type:__________________

Excessive Exposure at Home or Work To: Fumes_____ Dust______ Air-Borne Particles_____ Noise ______ Solvents _______

Family Medical History

	AGE	DISEASES	If Deceased, Cause of Death
Father	________	______________	______________________
Mother	________	______________	______________________
Siblings	________	______________	______________________

I certify that the above information is correct to the best of my knowledge. I will not hold my Doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________________

Signature of Patient or Legal Guardian **Date**

SOUTH LAKE EAR, NOSE & THROAT
9710 SAM FURR RD, STE. D
HUNTERSVILLE, NC 28078
PHONE: 704-896-1909 FAX:704-896-1926

MEDICATIONS & DRUG ALLERGIES

Do you currently take Aspirin? **YES** **NO**

MEDICINES YOU ARE CURRENTLY TAKING:

Medicine:	**Dosage:**
______________________	________________
______________________	________________
______________________	________________
______________________	________________
______________________	________________
______________________	________________

ANY KNOWN DRUG ALLERGIES? **YES** **NO**

IF YES, PLEASE LIST DRUGS & EXPLAIN REACTION:

____

____

____

____

PATIENT CONTACT RELEASE

In case we need to contact you, and you are not available, **may we leave a message** or a voicemail?

Home: Yes No Cell Phone: Yes No Work: Yes No **Please Initial:** __________

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION

If you would like us to verbally **release information regarding your medical records to someone other than yourself**, or if patient is a minor, other then parents, please indicate name and relationship:

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

______________________________ ______________________

Patient/Guardian's Signature **Date**

FINANCIAL ARRANGEMENTS & BILLING POLICIES

For your convenience, we will be happy to file your insurance when provided with the proper information. Deductibles, co-payments, co-insurance and non-covered services/products are to be paid in full at the time the services are rendered, unless otherwise arranged.

A list of the insurance plans we participate with is posted by the reception desk. Also, please keep in mind that the co-pay listed on your card may only apply to primary care doctors. In many cases benefits for specialist office visits and/or services are subject to a deductible. **It is ultimately your responsibility to know your network providers and benefits.** You are also responsible for procuring a referral from your PCP if required by your plan. (If you are unsure if your plan requires a referral please contact your insurance carrier as a lack of referral may result in denial of your claim and you will be responsible for the entire amount).

***** Please let us know immediately, if there has been a change in your name, address, phone number, as well as any changes in your insurance coverage. Per North Carolina law, providers have 90 days in which to file a claim. Delays in informing us of coverage changes could result in denial of your claim and you would be responsible for the charges incurred.**

Our policy requires that all balances be paid in full within 30 days of treatment. All returned checks are subject to a $20.00 charge.

Patient dismissal and what it means: Our practice reserves the right to dismiss a patient at any time and usually occurs when there are outstanding balances, patient/family are verbally abusive towards staff, patient is continually seeking narcotics, or any other issue that the MD sees fit. A dismissed patient will no longer be able to receive services from any provider at our practice. This includes office visits, prescription refills, RX samples, or medical advice. A 30 day notice would be given for patient to find another physician.

______________________________ ______________________

Patient/Guardian's Signature **Date**

ASHA (American Spec · Language and Hearing Association) rep all adults should have their hearing tested once every decade until age 50 and then in 3 year intervals thereafter. Risk factors for hearing loss may indicate testing as needed.

1. I have had a diagnostic hearing test __________ Yes ___________ No
2. If yes, when was your last hearing test? ____________

   Where was it completed? ________________________

3. What is your hearing aid experience?

- ❑ I have a hearing device and use it regularly on the ___ right ear ___ left ear.
- ❑ I have a hearing device, but don't use it, or use it only occasionally.
- ❑ I tried a hearing device, but returned it for credit.
- ❑ I have inquired about hearing devices at another office(s), but did not purchase at that time.
- ❑ I have never used a hearing device.

4. Please rank the following items on a scale of 1 to 4 in terms of importance to you when purchasing a hearing device. (1 = Most Important 2 = Important 3 = Somewhat Important 4=Least Important). Please use each number only *once*.

   ___ Sound Quality & Clarity ___ Durability/Reliability ___ Cost ___ Appearance

5. What motivated you to come in today?

___

___

___

6. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

   not motivated 1 2 3 4 5 6 7 8 9 10 very motivated

Listening Situation	How well do you hear in this situation?			How often are you in this situation?		
	Poor	Fair	Good	Often	Sometimes	Rarely
Television	☐	☐	☐	☐	☐	☐
Music	☐	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐	☐
Church	☐	☐	☐	☐	☐	☐
Meetings/Lectures	☐	☐	☐	☐	☐	☐
Work Place	☐	☐	☐	☐	☐	☐
Telephone Conversation	☐	☐	☐	☐	☐	☐
Car	☐	☐	☐	☐	☐	☐
Large Social Gathering	☐	☐	☐	☐	☐	☐
Quiet Room (1 to 2 people)	☐	☐	☐	☐	☐	☐