Name: _____

SOUTHERN E.N.T. ASSOCIATES, INC.
The Sinus, Ear, Nose, Throat, and Plastic Surgery Specialists

Weight: _____

DOB: _____

Patient Intake Form

Height: _____

- **PRESENT ILLNESS:**

Location of main symptom or problem (circle one or more): Ears / Nose or Sinuses / Throat / Other: _____

Describe your main symptom or problem. _____

_____

_____

How long have you had the problem? Days Weeks Months Years

What types of medical treatment have you had for this problem? (Circle all that apply)

NONE	**Steroid Shots or Pills**	**Antihistamines** - such as Zyrtec, Claritin, and Allegra	**Antibiotics –**
Ear Drops -		**Nasal Sprays –**	Please list: _____
Which type? _____		Please list: _____	_____
_____		_____	_____
Other: _____			

Did these treatments help? Yes / No / Somewhat

Have you had surgery for this problem or a similar problem in the past? (If so, what type of surgery and when did you have it?) _____

- **PAST MEDICAL HISTORY**

◻ Abnormal Heart Valve	◻ Cataracts	◻ Headaches	◻ Kidney Failure	◻ Skin Conditions
◻ Allergies	◻ Cirrhosis	◻ Heart Attack	◻ Lyme disease	◻ Sleep apnea
◻ Anemia	◻ COPD	◻ Hepatitis	◻ Mononucleosis	◻ Stomach problems
◻ Anxiety	◻ Depression	◻ Hiatal Hernia	◻ Multiple Sclerosis	◻ Stroke
◻ Arthritis	◻ Diabetes	◻ High Blood Pressure	◻ Osteoporosis	◻ Swimmers Ear
◻ Asthma	◻ Ear Infections	◻ HIV	◻ Prostate Problems	◻ Throat Problems
◻ Autoimmune Disorder	◻ Emphysema	◻ Incontinence	◻ Reflux	◻ Thyroid Problems
◻ Bladder Problems	◻ Fibromyalgia	◻ Irregular Heartbeat	◻ Seizures	◻ Tuberculosis
◻ Bleeding Disorder	◻ Glaucoma	◻ Keloids	◻ Sinus Infections	◻ Voice Problems

◻ Cancer: List Type (list type): _____

Other: _____

- **PAST SURGICAL HISTORY**

◻ Adenoidectomy	◻ Septoplasty	◻ Ear Drum Repair	Other Surgeries:	_____
◻ Tonsillectomy	◻ Rhinoplasty	◻ Mastoidectomy	_____	_____
◻ Ear Tubes (# ___)	◻ Sinus surgery	◻ Heart Surgery/Stent/Pacemaker	_____	_____

- **ALLERGIES:** Please list any medications, foods, or other substances (such as latex or tape) that the patient is allergic to.

◻ **No Allergies**

ALLERGIC TO	REACTION
_____	_____
_____	_____
_____	_____

- **MEDICATIONS**

Please list **ALL** medications (or provide list on separate paper). Please include over the counter medications.

MEDICATION	DOSE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

• **FAMILY HISTORY**

Check if any of these run in the family (only those related by blood):

☐ Autoimmune Disease	☐ Hearing Loss	☐ Problems with Anesthesia	☐ Cancer_____
☐ Bleeding/Coagulation Disorder	☐ Heart Disease	☐ Thyroid Disease	Other:_____
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis	

• **SOCIAL HISTORY**

Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Other

Occupation: Current: _____ Previous: _____

Noise Exposure: ☐ at Work ☐ In military ☐ Noise from Hobbies

Tobacco: ☐ Never Smoked ☐ Current Smoker: Amount: _____ per day # years smoking _____ ☐ Former Smoker: Stopped _____

Alcohol: ☐ Never Drank Alcohol ☐ Drink currently ☐ Beer ☐ Wine ☐ Liquor Amount per day _____
☐ Former drinker stopped _____

Caffeine: ☐ Coffee Oz/ day: _____ ☐ Tea Oz/ day: _____ ☐ Caffeinated soft drinks Oz/ day: _____

• **SPECIAL CONCERNS**

☐ Pregnant (Due: _____) ☐ Breastfeeding ☐ Taking Blood Thinners ☐ Require antibiotics for procedures ☐ Latex allergy

• **REVIEW OF SYSTEMS**

Check other active symptoms

Constitutional:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Loss of Appetite

Cardiovascular
☐ Chest Pain
☐ Fainting
☐ Irregular Heart

Respiratory:
☐ Shortness of Breath
☐ Cough
☐ Cough
☐ Coughing up blood
☐ Wheezing

Eyes:
☐ Allergic Conjunctivitis
☐ Recent Change in Vision
☐ Peri-Orbital Swelling

Gastrointestinal:
☐ Trouble Swallowing
☐ Heartburn
☐Bloody Vomiting

Integument:
☐ Changes to Existing Skin Lesion

Neurologic:
☐ Weakness
☐ Seizures
☐ Numbness

Endocrine:
☐ Heat Intolerance
☐ Cold Intolerance

Hematology / Lymphatic:
☐ Easy Bleeding
☐ Excessive Bleeding with Previous Surgeries
☐ Easy Bruising

Head/Ears/Nose/Throat
☐ Headache
☐ Vertigo (Spinning Sensation)
☐ Dizziness
☐ Lightheadedness
☐ Recent Head Injury
☐ Sinus Pain
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Nosebleeds
☐ Nasal Discharge
☐ Ear Discharge
☐ Ear Fullness
☐ Itching in Ear
☐ Ear Swelling
☐ Pressure Sensation in Ear
☐ Deviated Septum
☐ Decreased Sense of Smell
☐ Snoring
☐ Oral Ulcers
☐ Oral Sores
☐ Nasal Pain
☐ Purulent Nasal Discharge
☐ Gingival Bleeding
☐ Dental Problems
☐ Dentures
☐ Neck Stiffness
☐ Neck Pain
☐ Neck Tenderness
☐ Thyroid Mass
☐ Sore Throat
☐ Breath Odor
☐ Ear Pain
☐ Hearing Loss
☐ Ringing in Ears
☐ Roaring Sound in Ear
☐ Pulsatile Tinnitus
☐ Oral Blisters
☐ Oral White Spots
☐ Mouth Pain
☐ Dry Mouth
☐ Enlarged Tonsils
☐ Frequent Throat Cleaning
☐ Lump in Throat
☐ Hoarseness
☐ Change in Voice
☐ Difficulty Swallowing
☐ Neck Mass
☐ Swollen Glands
☐ Neck Swelling
☐ Hearing Aid

Patient Signature: _____ **Date:** _____

Patient Information Sheet

Last Name:	**First Name:**	**Middle Initial:**
Maiden Name:	**Preferred Name:**	**SSN :**
DOB:	**Driver's License #:**	**Sex:**
Marital Status:	**Preferred Provider:**	**Home #:**
Street Address:		**Work #:**
City, ST Zip:		**Cell #:**

Do you have an email address: ☐ Yes ☐ No
Email:

*By providing your email address you will have access to our patient portal. Through the patient portal you will have access to your health history, you can ask us questions, request refills, or request appointments.

Race (Circle One):
American Indian/Alaska Native Nat Hawaiian/Pacific Islander
Asian White Black/African American Other Race
Decline Unknown

Ethnicity (Circle One):
Hispanic/Latino Declined
Not Hispanic/Latino Unknown

Preferred Communication (Circle One) Email Patient Portal Mail Fax Phone Text

Primary Language Used (Circle One)
Arabic English French Greek Italian Korean Portugese Spanish
Chinese Filipino German Hindi Japanese Polish Russian Vietnamese

Preferred Pharmacy:
Name:
Address:
City, State Zip:

Family Physician:

Referring Physician:

Employer: **Emergency Contact:** **Phone #**

Primary Ins:
Policy Holder:
Policy Holder Relationship:
Policy Holder S.S.#:

Policy ID #:
Group #:
Policy Holder D.O.B.:

Secondary Ins:
Policy Holder:
Policy Holder Relationship:
Policy Holder S.S.#:

Policy ID #:
Group #
Policy Holder D.O.B.:

Responsible Party:
Address:
City, ST, Zip:

Social Security #
Date of Birth:

EVERYTHING ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. Furthermore, I / We authorize any medical treatment, anesthetics, or surgical procedures deemed necessary by physician.

Initial: _____

I / We authorize release of any medical information necessary to process insurance claims and authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered, including any and all rights to penalties and / or court costs, attorney's fees or collection agency fees up to 50% of the amount owed under Louisiana Law, including LA R.S. 22:657. If I am a participant in a managed care plan, I also authorize the audit of my chart by the plan. I / We understand if any services are not covered by insurance or my eligibility cannot be verified, I am responsible for charges incurred.

Initial: _____

I / We acknowledge that I have either received and / or was offered a copy of the office's Notice of Privacy Practices, which explains how my medical information will be used and / or disclosed. I / We acknowledge receipt and / or offering of a copy of Southern ENT's current office policies and disclosures of financial interests.

_____ Signature of Patient / Parent/ Guardian

_____ Printed Name

_____ Date

Southern E.N.T. Associates, Inc.

Permission to Verbally Discuss Health Information

In limited cases, we may provide health information to family members, or close friends who are directly involved in your care or the payment for your health care, **unless you tell us not to.** We may also discuss medical information in the presence of a family member or friend **if you are present and indicate that it is okay to do so.**

Example: If a family member or friend accompanies a patient into the exam room, we will assume, unless stated otherwise, that that person is entitled to receive information regarding the patient's treatment, but only during that visit unless indicated otherwise in writing below.

You can give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information **when you are not present.** You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records.

Permission to disclose or release medical records is handled completely separate.

Southern E.N.T. Associates, Inc. will not release confidential medical information regarding your treatment to family members or friends, unless they fall under one of the following categories:

- Parent of a minor under the age of 18
- Legal Guardian
- Emergency Contact
- Persons authorized by the patient
- Instances permitted by HIPAA
- As we may reasonably infer from the circumstances.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If a relative or friend is helping with billing questions
- If a friend or relative calls to verify an appointment time
- If a relative or friend comes in and asks if you are here and in or out of surgery or the procedure room

If you change your mind when you have another appointment with us, you can complete a new permission form. You must notify us **IN WRITING.**

I give permission to Southern E.N.T. Associates, Inc. to VERBALLY discuss the following information about me (Check all that apply) with the following person(s):

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

- ☐ **Appointment Information**
- ☐ **Medical Information, including my symptoms, diagnosis, medications, and treatment plan**
- ☐ **Lab/test results**
- ☐ **Billing and payment information**
- ☐ **My location in the facility**

I understand that I have the right to revoke my permission at any time except where Southern E.N.T. Associates, Inc. has already made disclosures relying upon this permission request. **I understand I must notify Southern E.N.T. Associates, Inc. in writing if I want to revoke my permission.**

I acknowledge and agree that Southern E.N.T. Associates, Inc. and any other affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers.

Signature of Patient/Authorized Representative: _____

Relation to Patient: _____

Witness: _____ **Date and Time:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1986 ("HIPPA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PH") is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation. Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery, Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible. We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPPA; and
- Other uses and disclosures not described in this notice.

You May revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI, The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if you're unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 26, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from your office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.