

## Ear, Nose & Throat Consultants Patient Medical Hx Form

Name: \_\_\_\_\_  
 Date: \_\_\_/\_\_\_/\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

**Medications** (include Aspirin, vitamins and herbal remedies, birth control and over-the-counter allergy and cold meds): \_\_\_\_\_

**Allergies to Medications:** \_\_\_ None known

Med \_\_\_\_\_ rash/hives/swelling/anaphylaxis/breathing problem  
 Med \_\_\_\_\_ rash/hives/swelling/anaphylaxis/breathing problem  
 Med \_\_\_\_\_ rash/hives/swelling/anaphylaxis/breathing problem

<b>Your Past Medical History:</b>	<u>Yes</u>	<u>No</u>	(please explain if yes)
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	_____
Thyroid disease	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	_____
Heart Murmur	<input type="radio"/>	<input type="radio"/>	_____
Elevated Cholesterol	<input type="radio"/>	<input type="radio"/>	_____
Respiratory/lung disease	<input type="radio"/>	<input type="radio"/>	_____
Digestive/stomach/intestinal disease	<input type="radio"/>	<input type="radio"/>	_____
Urologic/kidney disease	<input type="radio"/>	<input type="radio"/>	_____
Neurologic/seizure/depression	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma/eye disorder	<input type="radio"/>	<input type="radio"/>	_____
Environmental Allergy	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	_____
Other Medical Disease	<input type="radio"/>	<input type="radio"/>	_____

Previous Surgery (include operations and dates): \_\_\_\_\_

**Social Hx**

What is your occupation? \_\_\_\_\_  
 How much do you smoke? \_\_\_\_\_ packs/day (Check if none )  
 If none, did you ever smoke? \_\_\_\_\_ If yes, when did you quit? \_\_\_\_\_  
 How often do you drink alcohol? \_\_\_\_\_

**Family Hx**

Please note which **relatives** have had the following:

	Yes	No	(please explain if yes)
Cancer	<input type="radio"/>	<input type="radio"/>	_____
Hearing Loss	<input type="radio"/>	<input type="radio"/>	_____
Allergy	<input type="radio"/>	<input type="radio"/>	_____
Bleeding disorders	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
Headaches	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	_____
Adverse reaction to anesthesia	<input type="radio"/>	<input type="radio"/>	(Malignant Hyperthermia?) _____

Reviewed by: \_\_\_\_\_ PA-C Date \_\_\_\_\_ M.D. Date \_\_\_\_\_

## Ear, Nose & Throat Consultants Patient Medical Hx Form, page 2

Patient name \_\_\_\_\_

### Perinatal/Birth Hx

Premature/Infection/Jaundice/Intubation/Oxygen/Breathing difficulties? \_\_\_\_\_

Newborn hearing test: Normal/Abnormal/ Not known / Not done \_\_\_\_\_

### Review of Systems

Please indicate whether **you presently** have any of the following symptoms:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
<b>Constitutional</b>			<b>Genitourinary</b>		
Chills	<input type="radio"/>	<input type="radio"/>	Troubles with urination	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	(Females) Are you pregnant		
Weight loss/gain	<input type="radio"/>	<input type="radio"/>	or trying?	<input type="radio"/>	<input type="radio"/>
Daytime fatigue	<input type="radio"/>	<input type="radio"/>	Post-menopausal	<input type="radio"/>	<input type="radio"/>
<b>Eyes</b>			<b>Musculoskeletal</b>		
Eye pain	<input type="radio"/>	<input type="radio"/>	Joint pain	<input type="radio"/>	<input type="radio"/>
Watery/itchy eyes	<input type="radio"/>	<input type="radio"/>	Muscle aches	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>	<b>Skin</b>		
<b>Ears, Nose, Mouth, Throat</b>			Rash/itching	<input type="radio"/>	<input type="radio"/>
Ear pain	<input type="radio"/>	<input type="radio"/>	Hives	<input type="radio"/>	<input type="radio"/>
Ear itch	<input type="radio"/>	<input type="radio"/>	Change in skin/hair	<input type="radio"/>	<input type="radio"/>
Ear drainage	<input type="radio"/>	<input type="radio"/>	<b>Neurological</b>		
Dizziness /Loss of balance	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Ear noises/tinnitus	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>	Slurred speech	<input type="radio"/>	<input type="radio"/>
Post-nasal Drip	<input type="radio"/>	<input type="radio"/>	<b>Psychiatric</b>		
Sinus pain/pressure	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>
Nasal congestion	<input type="radio"/>	<input type="radio"/>	Anxiety or panic disorder	<input type="radio"/>	<input type="radio"/>
Loss of smell/taste	<input type="radio"/>	<input type="radio"/>	<b>Endocrine</b>		
Hoarseness	<input type="radio"/>	<input type="radio"/>	Thyroid Overactive	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	Thyroid Underactive	<input type="radio"/>	<input type="radio"/>
Throat dryness/tickle	<input type="radio"/>	<input type="radio"/>	Thyroid nodules/lumps	<input type="radio"/>	<input type="radio"/>
Throat clearing	<input type="radio"/>	<input type="radio"/>	<b>Hematologic/Lymphatic</b>		
Snoring	<input type="radio"/>	<input type="radio"/>	Swollen glands	<input type="radio"/>	<input type="radio"/>
<b>Cardiovascular</b>			Night sweats	<input type="radio"/>	<input type="radio"/>
Irregular heart beats	<input type="radio"/>	<input type="radio"/>	Bleeding disorder	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Clotting disorder	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Easy bruising	<input type="radio"/>	<input type="radio"/>
Heart failure	<input type="radio"/>	<input type="radio"/>	<b>Allergic/Immunologic</b>		
Heart Murmur	<input type="radio"/>	<input type="radio"/>	Sneezing	<input type="radio"/>	<input type="radio"/>
<b>Respiratory</b>			Itchy Nose/Eyes	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	Previous allergy tests	<input type="radio"/>	<input type="radio"/>
Short of Breath	<input type="radio"/>	<input type="radio"/>			
Wheeze/Asthma	<input type="radio"/>	<input type="radio"/>			
Coughing up blood	<input type="radio"/>	<input type="radio"/>			
<b>Gastrointestinal</b>			Height: _____	Weight: _____	
Heartburn/burping	<input type="radio"/>	<input type="radio"/>			
Trouble swallowing	<input type="radio"/>	<input type="radio"/>			

Reviewed by: \_\_\_\_\_ PA-C Date \_\_\_\_\_ M.D. Date \_\_\_\_\_

## Ear, Nose and Throat Consultants Patient Registration Form

Date: \_\_\_\_\_

### Name / Address

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
 Home Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone: (    ) \_\_\_\_\_ - \_\_\_\_\_  
 Work Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

### Statistics

Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female  
 Marital Status (Circle one) Married, Single, Divorced, Widow, Other \_\_\_\_\_  
 Spouse / Next of Kin: \_\_\_\_\_ Contact Tel #: (    ) \_\_\_\_\_ - \_\_\_\_\_

### Referring Physician

Primary Care Doctor: \_\_\_\_\_ Referring MD: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel: (    ) \_\_\_\_\_ - \_\_\_\_\_

### Insurance Information

<b>Primary Insurance Company</b>	<b>Identification or Certificate #</b>	<b>Group #</b>
_____	_____	_____
Name of insurance, if not self: _____	<b>Relation to Insured (circle one)</b>	
Insured Adr1: _____	Self, Spouse, Child	
Insured Adr2: _____		
Insured City: _____ State: _____ Zip: _____		
Insured Date of Birth: ____/____/____	Insured Soc. Sec. #: _____ - _____ - _____	
Insured Employer: _____		
<b>Secondary Insurance Company</b>	<b>Identification or Certificate #</b>	<b>Group #</b>
_____	_____	_____
Name of insured, if not self: _____	<b>Relation to Insured (circle one)</b>	
Insured Adr1: _____	Self, Spouse, Child	
Insured Adr2: _____		
Insured City: _____ State: _____ Zip: _____		
Insured Date of Birth: ____/____/____	Insured Soc. Sec. #: _____ - _____ - _____	
Insured Employer: _____		

### Other Insurance

Is this Workers Comp.? Y/N    Is this Motor Vehicle? Y/N    Is this Personal Injury? Y/N

### Authorization and financial Policy

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS.  
 I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO ENT CONSULTANTS FOR SERVICES PROVIDED.  
 I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL BALANCES NOT PAID BY MY INSURANCE COMPANY

Your Signature: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, hereby acknowledge that I have received Ear, Nose and Throat Consultants' Notice of Privacy Practices. I understand that I can contact the office manager, at 781-729-8845 if I have any further questions or concerns about the office's privacy policy.

I understand that I am entitled to receive updates upon request if Ear, Nose and Throat Consultants Notice of Privacy Practices is amended or changed in a material way.

Please note the following special request(s) for the privacy of my records, health care, and communications:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

OR

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Patient's Personal Representative**

\_\_\_\_\_  
**Authorization to Pay Benefits to Physician:** I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charges for those services.

**Authorization to Release Information:** I hereby authorize the Physician to release any information acquired during the course of my examination or treatment for purposes of treatment, payment, or health operations.

\_\_\_\_\_  
**Patient's Signature (Parent or Guardian)**

\_\_\_\_\_  
**This Section to be filled out by Office Staff only.**

To be filled out if unable to obtain written acknowledgement from the patient or guardian.

On \_\_\_\_\_, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this written acknowledgement.

Patient did not understand the request to sign the written acknowledgement.

Other (please specify details) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# HIPPA Notice of Privacy Practices

Ear, Nose and Throat Consultants

**This notice explains how your medical information about you can be used and disclosed and how you can access it.**

This Notice of Privacy Practices describes how we may use and disclose your health record or protected health information (PHI) for treatment, payment, and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected Health Information is information about you including demographics that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The doctors and staff of Ear, Nose and Throat Consultants are committed to maintaining the privacy of your health information.

## Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your health care and treatment to provide health care services, pay your medical bills, support our office practice operation, and any other use required by law. We are required to abide by the terms of the notice currently in effect.

**Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This can include communication with a third party, for example, to a referring physician, an emergency room doctor, or a home health agency that will be providing home services.

**Payment:** We will use your PHI as needed to obtain payment for health care services we have delivered. For example, we must provide a diagnosis to your health insurance company for proper billing for an office or hospital visit.

**Health Care Operations:** We may use or disclose, as needed, your PHI to support our business activities. These may include but are not limited to quality assessments, employee reviews, training of staff and medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students who see you when you are in the hospital. In addition, we may have you sign in when you register at our front desk. We may call your name when we are ready to bring you to an exam room. We may disclose your PHI when reminding you of an appointment.

**Disclosures without Authorization:** Your PHI may be used or disclosed without your authorization in the following situations: Required by law; Public Health issues as required by law; Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Correctional Institutions; Required Uses and Disclosures. Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your health record is the physical property of Ear, Nose and Throat Consultants, Inc. The information in the record is accessible to you.

## **Your Rights**

Following is a statement of your rights with regard to your protected health information (PHI)

**You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

**You have the right to request a restriction of your PHI.** This means that you may ask us to not use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**Your physician is not required to agree to a restriction that you request.** If the provider believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use a different Healthcare Professional.

**You have the right to request receipt of confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively.

**You may request to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

**We reserve the right to change the terms of this notice and will inform you by mail of any changes.** You then have the right to object or to withdraw from the practice as provided in this notice.

**Complaints.** If you have any questions or would like additional information, you may contact our office manager, Mr. Ray O'Shea at 781-729-8994. You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice becomes effective on or before April 14, 2003.