The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient Name: _____

Sino-Nasal Outcome Test (SNOT-22)

Patient Phone: _____ Date: _____

1. Consider how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale. 2. Please mark the most important items affecting your health (maximum of 5 items), right column.	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		○
2. Nasal Blockage	0	1	2	3	4	5		○
3. Sneezing	0	1	2	3	4	5		○
4. Runny nose	0	1	2	3	4	5		○
5. Cough	0	1	2	3	4	5		○
6. Post-nasal discharge	0	1	2	3	4	5		○
7. Thick nasal discharge	0	1	2	3	4	5		○
8. Ear fullness	0	1	2	3	4	5		○
9. Dizziness	0	1	2	3	4	5		○
10. Ear pain	0	1	2	3	4	5		○
11. Facial pain/pressure	0	1	2	3	4	5		○
12. Decreased sense of smell/taste	0	1	2	3	4	5		○
13. Difficulty falling asleep	0	1	2	3	4	5		○
14. Wake up at night	0	1	2	3	4	5		○
15. Lack of a good night's sleep	0	1	2	3	4	5		○
16. Wake up tired	0	1	2	3	4	5		○
17. Fatigue	0	1	2	3	4	5		○
18. Reduced productivity	0	1	2	3	4	5		○
19. Reduced concentration	0	1	2	3	4	5		○
20. Frustrated/restless/irritable	0	1	2	3	4	5		○
21. Sad	0	1	2	3	4	5		○
22. Embarrassed	0	1	2	3	4	5		○

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England.

SOUTH FLORIDA ENT ASSOCIATES

MEDICAL HISTORY

Patient Name: _____ Birthdate: ____/____/____ Age: _____

SEX: ☐M ☐F If female, are you pregnant? ☐Y ☐N Height: _____ Weight: _____

Chief Complaint/Reason For Visit: _____ Referring Doctor/PCP: _____

Current Symptoms (Circle any positives):

HEAD-SINUSES: FACIAL PAIN / HEADACHES / PRESSURE / CONGESTION / BLEEDING / SNEEZING / RUNNY NOSE / LOSS OF SMELL / ITCHING / POST NASAL DRAINAGE	NONE ☐
EARS-HEARING: PAIN / HEARING LOSS / RINGING IN THE EARS / PRESSURE / LOSS OF BALANCE / ITCHING / DRAINING / EAR WAX	NONE ☐
MOUTH: DENTAL PROBLEM / DRY MOUTH / BAD BREATH / COLD SORES / ULCERATIONS / PAROTITIS / BLEEDING	NONE ☐
THROAT: SORE / HOARSENESS / LOSS OF TASTE / BAD TASTE / WHITE SPOTS / LESIONS / SNORING / DIFFICULTY SWALLOWING	NONE ☐
RESPIRATORY: SHORTNESS OF BREATH / COUGH / WHEEZING / ASTHMA	NONE ☐
GI: HEARTBURN / REFLUX / DIARRHEA / NAUSEA / VOMITING / GASTRITIS	NONE ☐
NEUROLOGICAL: HEADACHES / PASSING OUT / DIZZINESS / NUMBNESS	NONE ☐
CONSTITUTIONAL SYMPTOMS: FATIGUE / FEVER / CHILLS / NIGHT SWEATS / WEIGHT LOSS OR GAIN / FAINTING	NONE ☐
EYES: DOUBLE VISION / ITCHING / VISION LOSS / PAIN / BURNING / TEARING / DRY EYES	NONE ☐
SKIN: RASH / ITCHING / LESIONS / HIVES	NONE ☐
MUSCULOSKELETAL: JOINT PAIN / JAW PAIN	NONE ☐
HEMATOLOGIC-LYMPHATIC: NECK MASS / BRUISING	NONE ☐

Medical History (Check if you have history of the following)

- ☐ HEAD OR FACIAL TRAUMA
- ☐ SINUS SURGERY
- ☐ MASTOIDITIS
- ☐ ASTHMA
- ☐ SLEEP APNEA
- ☐ REFLUX
- ☐ HIATAL HERNIA
- ☐ STROKE
- ☐ SEIZURES
- ☐ HYPERTENSION
- ☐ MITRAL VALVE PROLAPSE
- ☐ PAST HEART ATTACKS
- ☐ PACEMAKER
- ☐ HIGH CHOLESTEROL
- ☐ GLAUCOMA
- ☐ SKIN CANCER
- ☐ ARTHRITIS
- ☐ MUSCULAR DYSTROPHY
- ☐ CONGENITAL PROBLEMS
- ☐ KIDNEY STONES
- ☐ ANXIETY
- ☐ SLEEP DISORDER
- ☐ MEMORY LOSS
- ☐ DRUG ADDICTION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ OBESITY
- ☐ THYROID DISEASE
- ☐ PARATHYROID DISEASE
- ☐ PITUITARY DISEASE
- ☐ NECK MASSES
- ☐ ANEMIA
- ☐ IMMUNE PROBLEMS
- ☐ PVT PULMONARY EMBOLISM
- ☐ FRACTURES
- ☐ OSTEOPOROSIS
- ☐ LUPUS
- ☐ DIALYSIS
- ☐ PROSTATE PROBLEMS
- ☐ OTHER _____

Surgical History (List all past surgeries)

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History of Medical Problems

Relationship	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently using tobacco products? ☐Y ☐N If yes, quantity per day: _____

If you are a former tobacco product user, what was the frequency of use per day? _____ For how long? _____

Do you drink alcohol? ☐Y ☐N If yes, amount: _____ How often: _____

Do you currently have or have you in the past had a problem with substance abuse ? ☐Y ☐N

Please list all allergies below(including medication, environmental, and/or food allergies): ☐ No Allergies

_____

List all medications w/mg you are currently taking (including all over the counter medications and vitamins): ☐ None

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

(If patient is a minor, please indicate the person completing the Medical History and the relationship to patient)

Relationship to Patient: _____ Name of Parent/Guardian: _____

South Florida ENT Associates, P.A.

ADULT PATIENT INFORMATION PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ **DATE OF BIRTH:** _____ / _____ / _____

ADDRESS: _____ **APT /UNIT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____-_____

HOME TEL: (____) _____ **ALTERNATE TEL:** (____) _____

SEX (Circle one): Male Female **MARITAL STATUS** (Circle one): Single Married Widowed Divorced

ETHNICITY (Circle one): Hispanic Non-Hispanic **RACE:** _____

LANGUAGE SPOKEN: English Spanish **Other:** _____ **Email:** _____

PCP/REF PHYSICIAN: _____ **PHONE:**(____) _____ **FAX:**(____) _____

PHARMACY NAME: _____ **PHARMACY PHONE:** (____) _____

EMPLOYER_____EMPLOYER TEL (____) _____

EMPLOYER ADDRESS _____OCCUPATION _____

SPOUSE'S NAME _____ **SPOUSE DOB:** _____ / _____ / _____

SPOUSE'S SOCIAL SECURITY _____SPOUSE'S CELL/ALTERNATE # _____

****

EMERGENCY CONTACT/RELATIONSHIP _____

PHONE NUMBER: (____) _____ ALTERNATE NUMBER: (____) _____

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI) with your spouse or other family member? **(CIRCLE) YES NO**

NAME OF FAMILY MEMBER_____**RELATIONSHIP**_____

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? **(CIRCLE) YES NO**

IF YES, WHAT PHONE NUMBER? _____

HEALTH INSURANCE *A photocopy of these assignments shall be valid as the original

***PRIMARY INSURANCE:** _____ POLICY# _____ GRP# _____

INSURED'S NAME _____ INSURED'S DOB: _____

INSURED'S SS# _____ RELATIONSHIP TO PT: _____

***SECONDARY INSURANCE**: _____ POLICY# _____ GRP# _____

INSURED'S NAME _____ INSURED'S DOB: _____

INSURED'S SS# _____ RELATIONSHIP TO PT: _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize South Florida ENT Associates, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to South Florida ENT Associates, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE: _____ **DATE**: _____

SOUTH FLORIDA ENT ASSOCIATES, P.A.
Care Center 6

Patient Acknowledgement of Receipt of the Notice of Privacy Practices and Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the South Florida ENT Associates, P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that South Florida ENT Associates, P.A. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the South Florida ENT Associates, P.A Corporate office at (305) 558-3724.

I acknowledge that I have received a copy of the South Florida ENT Associates, P.A. Notice of Privacy Practices.

_____ _____

Patient Name Date

_____

Signature of Patient □

_____ _____

Patient Legal Representative (if applicable) Date

_____

Signature of Legal Representative

_____

FOR PHYSICIAN'S OFFICE USE ONLY

_____

Office Staff Member Obtaining Signature

_____

Reason Signature and Date were not obtained

- □ **Individual Refused to Sign**
- □ **Communication barriers prohibited obtaining the acknowledgement**
- □ **An emergency situation prevented us from obtaining acknowledgement**
- □ **Other (Please specify)**

_____

Outstanding Balance Policy

It is our office policy that all past due accounts be contacted via statements, letters and/or phone calls in accordance with our internal policy. If resolution is not made after the attempts from our internal collection department, the account will be sent to our collection agency. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Collection Fees

I understand that in the event my account is placed in collection status and, as a result, turned over by the practice to a debt collector, a fee, in the amount of 30% of my account balance, will be added to my outstanding balance. I understand this amount is a fee and not interest, which fee will be added to my account balance, to be collected by those debt collectors engaged by the practice. I understand this fee, together with my account balance, will be my personal responsibility to pay in full.

Notice to Patients

Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary. We do our best to determine if the patient will be covered for the services to be provided during your visit, however, plan benefits vary from plan to plan and we may not be aware of any specific limitations included in your specific benefit plan.

Authorization & Assignment of Benefits

I authorize SFENTA to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to SFENTA I understand that I am financially responsible to the Provider for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

Divorced Parents of Minor Children

I acknowledge that, if my minor child is treated by SFENTA and his or her parents are divorced, the parent who signs in such minor child into the practice on the date this Agreement is executed (the "Responsible Parent"), accepts responsibility for payment for services rendered on such day, as well as for all future services rendered by the practice for such minor child. We do not promise nor are we obligated to send bills, patient records or related communications to the other parent/legal guardian pertaining to issues of payment or communications. We will communicate about treatment and payment with the Responsible Parent as to any and all matters from and after the date of this Agreement. I acknowledge that the parents are responsible to communicate with each other about treatment and payment issues involving their minor child.

Communication

I consent to receive calls, text messages and emails from SFENTA and its Business Associates regarding my account information, which may contain Personal Health Information (PHI), at the listed phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Cell Phone: _____ Home Phone: _____

Definitions

For purposes of this Agreement, the terms "we", "our" the "practice" and "SFENTA" shall mean South Florida ENT Associates and the terms "I", "my", "you" and "your" refer to the patient or responsible party for such patient executing this Agreement below.

I have read and understand the practice's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Patient Name Patient DOB

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's Signature Date