Name:
DOB:
Chart:
Age:
Date:

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M/R RELEASE, MESSAGES, FINANCIAL POLICY

I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE INSURANCE CARRIER(S) VIA FAX OR MAIL. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED. **I AUTHORIZE THE RELEASE** OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE PHYSICIANS INVOLVED IN THE CARE VIA FAX OR MAIL. **I FURTHER AUTHORIZE** OTOLARYNOLOGY ASSOCIATES TO LEAVE THE RESULTS OF THE ABOVE PATIENT'S EXAMINATIONS AND TESTS, INCLUDING MESSAGES, APPOINTMENT REMINDERS, LABORATORY TESTS AND X-RAYS ON THE ANSWERING MACHINE/VOICEMAIL AT THE PHONE NUMBER PROVIDED. **I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS** OF THE HEALTH SERVICES FOR THE ABOVE PATIENT, AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM THE INSURANCE COMPANY. I UNDERSTAND THE DOCTOR'S CHARGE MAY EXCEED THE INSURANCE CARRIER'S PAYMENT AND IF THE CHARGE IS MORE THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THE DIFFERENCE IF FOR ANY REASON THE ABOVE PATIENT'S ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION, ATTORNEY FEES, AND COURT COSTS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

_____ By signing below, I acknowledge that I have received Otolaryngology Associates, LLC* Notice of Privacy Practices ("Notice").

* This includes Whisper Hearing Centers, Biggerstaff & Associates and Balance Point

PRESCRIPTION MEDICATION HISTORY CONSENT

_____ I agree that Otolaryngology Associates, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ Date _____
Signature (Patient or Authorized Representative)

_____
Printed (Patient or Authorized Representative)

_____
Printed Patient Name

Name:
DOB:
Chart:
Age:
Date:

OTOLARYNGOLOGY ASSOCIATES PHYSICIAN _____
(FOR OFFICE USE ONLY)

PATIENT NAME _____ _____ INITIAL
(LAST) (FIRST) (MIDDLE)

PATIENT ADDRESS _____ **Last 4 SS#**

CITY _____ STATE _____ ZIP _____

PRIMARY ( ) _____ Home Cell SECONDARY ( ) _____ Home Cell OTHER ( ) _____

SOCIAL SECURITY NUMBER ____ - ____ - ____ ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWEI

DATE OF BIRTH ____ / ____ / ____ AGE _____ SEX: M / F (CIRCLE ONE)

EMAIL ADDRESS (FOR PATIENT PORTAL ACCESS) _____

RACE: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White
☐ More than one race ☐ Unreported/Refused to report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Unreported/Refused to report LANGUAGE: _____

SPOUSE _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S MOTHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S FATHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

ADDRESS IF DIFFERENT THAN PATIENT'S _____

REFERRING M.D. _____ / _____
(ADDRESS)

FAMILY M.D. _____ / _____
(ADDRESS)

NOTIFY IN CASE OF EMERGENCY _____ / _____ PHONE ( ) _____
(RELATIONSHIP)

PHARMACY _____ LOCATION _____ PHONE ( ) _____

REASON FOR BEING SEEN TODAY _____

ANY HEARING CONCERNS: ☐ YES ☐ NO DO YOU HAVE ANY DIZZINESS: ☐ YES ☐ NO

ANY PROBLEMS WITH ALLERGIES: ☐ YES ☐ NO

****THIS SECTION MUST BE COMPLETED IN FULL, EVEN IF CARD IS COPIED****

PRIMARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH ____ / ____ / ____

POLICY HOLDER'S NAME _____ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPAREN

SECONDARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH ____ / ____ / ____

POLICY HOLDER'S NAME _____ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPAREN

Name:
DOB:
Chart:
Age:
Date:

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HEALTH HISTORY DATA SHEET

(Complete this form in ink) **Please Print**

Provider _____ HEIGHT _____
WEIGHT _____

FAMILY PHYSICIAN _____

CHECK (√) BELOW ANY ILLNESSES YOU HAVE HAD.

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Bronchitis
- ☐ Cancer - Tumors
  Type_____
- ☐ Chicken Pox
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Disease
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
  Type_____
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Neuritis
- ☐ Obstructive Sleep Apnea
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers (Leg)
- ☐ Ulcers (Duodenal)

List Other Illnesses

_____
_____
_____
_____
_____

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No
Please Print List Below

_____
_____
_____
_____

Are you currently taking any vitamins, herbal supplements or over the counter medications? ☑ Yes ☐ No **Please Print List Below**

_____
_____
_____
_____

OPERATIONS Please Print

TYPE	MONTH - YEAR	NAME OF HOSPITAL

FRACTURES Please Print

ALLERGIES

CHECK (√) BELOW IF YOU ARE ALLERGIC TO:

☐ **NO ALLERGIES**

- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine
- ☐ Demerol
- ☐ Aspirin
- ☐ Morphine
- ☐ Latex

Please Print Other Drug Allergies Not Listed On The Left

_____
_____
_____

Name:
DOB:
Chart:
Age:
Date:

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FAMILY HEALTH HISTORY DATA SHEET Physician: PriDrName

FAMILY HISTORY (CHECK √ BELOW IF ANY OF THE CONDITIONS HAVE OCCURRED ON EITHER SIDE OF PATIENT'S FAMILY)

List Any Other Illnesses

- ☐ Allergies
- ☐ Bleeding Tendencies
- ☐ Blood Disease
- ☐ Bone Disease
- ☐ Cancer or Tumors
- ☐ Cardiovascular Disease (Heart)
- ☐ Congenital Deformities
- ☐ Diabetes
- ☐ Gastrointestinal Disease
- ☐ Kidney Disease
- ☐ Mental Disease
- ☐ Pulmonary Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis

Do you have a pacemaker? ☐ Yes ☐ No

Are you HIV positive? ☐ Yes ☐ No

Smoking Status: ☐ Never Smoker ☐ Current every day smoker ☐ Current someday smoker ☐ Former smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked Start Date: _____ Quit Date: _____

Do you use alcohol? ☐ Yes ☐ No Amount per day _____

Do you use illegal substances? ☐ Yes ☐ No

Have you or anyone in your family had problems with anesthesia? ☐ Yes ☐ No Attend Day Care: ☐ Yes ☐ No

ROS (CHECK √ BOX IF YOU HAVE HAD THESE SYMPTOMS IN THE PAST YEAR)

- Constitutional: ☐ Weight Loss ☐ Fatigue ☐ Fever
- Eyes: ☐ Double or Blurry Vision ☐ Blindness ☐ Red Eyes
- Cardiovascular: ☐ Chest Pain ☐ Shortness of Breath on Exertion ☐ Cyanosis ☐ Ankle Edema ☐ Frequent Urination at Night
- Respiratory: ☐ Shortness of Breath ☐ Cough ☐ Coughing Blood ☐ Wheezing ☐ Use Oxygen
- GI: ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Diarrhea ☐ Indigestion
- GU: ☐ Blood in Urine ☐ Burning ☐ Urinary Infections
- Musculoskeletal: ☐ Muscle Weakness ☐ Pain ☐ Tenderness ☐ Joint Swelling
- Skin: ☐ Rash ☐ Lumps ☐ Sores ☐ Loss of Hair
- Neuro: ☐ Headaches ☐ Blackouts ☐ Paralysis ☐ Numbness ☐ Head Injury
- Psychiatric: ☐ Nervousness ☐ Anxiety ☐ Memory Loss ☐ Sleep Disturbances
- Hematology/Lymphatic: ☐ Anemia ☐ Bruise Easy ☐ Enlarged Lymph Nodes
- Endocrine: ☐ Excessive Thirst ☐ Intolerance of Heat or Cold ☐ High Blood Sugar
- Allergy/Immunologic: ☐ Inhalant or Food Allergy ☐ Itchy ☐ Frequent Infections

Have you ever taken Cortisone? ☐ Yes ☐ No

☐ Orally ☐ Injection

If yes, Month _____ Year _____

Please Print Month _____ Year _____

Month _____ Year _____

VACCINATIONS (Please select the ones you have had)

☐ Mumps ☐ Tetanus ☐ Rubella ☐ Influenza ☐ Pneumococcal ☐ Hepatitis

Name:
DOB:
Chart:
Age:
Date:

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OA Physician: _____

Contact Information for Protected Health Information

I, _____ (patient's name) DOB: _____

request that the following methods be adhered to for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnoses, test results, dates of service as described in the Notice of Privacy Practices).

Please check any or all of the three options that apply:

Option A:

☐ OA may disclose information by telephone to people designated below. **This document does not allow the people listed below to receive medical records. For OA to allow non patients to receive medical records, a release of information form must be signed by the patient or their power of attorney.**

Name	Phone Number	Relationship

Option B:

☐ You may leave Protected Health Information on my answering machine/voicemail at this phone number: (_____) _____

Option C:

☐ Other _____

Document is good for one year from date signed.

_____ _____
Patient's Printed Name Social Security Number

_____ _____
Patient's Signature (or Guardian if a minor) Date

_____ _____
Witness (optional) Date