

New Patient Information

Please complete all fields. If any item does not apply, please write N/A.

<p>Patient Full Name: _____ Age _____ Date of Birth _____ Sex _____ SSN _____ Marital Status: _____ Home Address _____ City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____</p>	<p>Referring Doctor's Name: _____ Phone () _____ ***** Primary Doctor's Name _____ Phone () _____</p>
<p>Patient's Employer: _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Patient's Occupation _____</p>	<p>Complete <u>only</u> if patient is a <u>minor</u> or <u>student</u> Mother's Name: _____ SSN _____ DOB: _____ Occupation _____ Employer _____ City _____ State _____ Phone Number _____ ext _____ Father's Name: _____ SSN _____ DOB: _____ Occupation _____ Employer _____ City _____ State _____ Phone Number _____ ext _____</p>
<p>Patient's Spouse _____ Soc. Sec. Number _____ DOB _____ Employer _____ Work phone number: _____</p>	
<p>Emergency Contact: Name _____ Phone _____ Relationship to Patient _____</p>	
<p>Who is responsible for payment, if not Patient? Name _____ Home Phone Number _____ Address _____ Work Phone Number _____</p>	
<p align="center"><u>Primary Insurance</u></p> <p>Insurance Company Name _____ Subscriber Name _____ SSN _____ Date of birth _____ Subscriber relation to Patient _____ Copay _____ Effective Date _____ Employer _____</p>	<p align="center"><u>Supplemental Insurance</u></p> <p>Insurance Company Name _____ Subscriber Name _____ SSN _____ Date of birth _____ Subscriber relation to patient _____ Copay _____ Effective Date _____ Employer _____</p>
<p>Authorization: I hereby authorize Kentucky Ear, Nose & Throat to furnish information to insurance carriers concerning my illness/accident and treatment and I hereby assign Kentucky Ear, Nose and Throat all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance.</p> <p>Signature of PATIENT or Guardian: _____ Date _____</p>	

Name: _____

9. REVIEW OF SYSTEMS: Check any symptoms that you /the patient have now or have recently had.		
Fever <input type="checkbox"/>	Nasal Congestion <input type="checkbox"/>	Frequent Cough <input type="checkbox"/>
Sleeping Problems <input type="checkbox"/>	Nasal Obstruction <input type="checkbox"/>	Night Time Cough <input type="checkbox"/>
Unintentional Weight Loss <input type="checkbox"/>	Clear Nasal Drainage <input type="checkbox"/>	Shortness of Breath <input type="checkbox"/>
Feeling Cold <input type="checkbox"/>	Colored Nasal Drainage <input type="checkbox"/>	Excessive Snoring <input type="checkbox"/>
Hives <input type="checkbox"/>	Post Nasal Drainage <input type="checkbox"/>	Witnessed Sleep Apnea <input type="checkbox"/>
Blurred Vision <input type="checkbox"/>	Poor Sense of Smell <input type="checkbox"/>	Wheezing <input type="checkbox"/>
Loss of Vision <input type="checkbox"/>	Frequent Nosebleeds <input type="checkbox"/>	Painful Joints <input type="checkbox"/>
Itchy or Watery Eyes <input type="checkbox"/>	Sneezing <input type="checkbox"/>	Headache <input type="checkbox"/>
Painful Eyes <input type="checkbox"/>	Hoarseness or Voice Changes <input type="checkbox"/>	Severe Facial Pain <input type="checkbox"/>
Balance Problems <input type="checkbox"/>	Change in Sense of Taste <input type="checkbox"/>	Seizures <input type="checkbox"/>
Whirling/Spinning Sensation <input type="checkbox"/>	Dentures / Partial Plates <input type="checkbox"/>	Bleed Excessively After an Injury <input type="checkbox"/>
Hearing Loss <input type="checkbox"/>	Heartburn <input type="checkbox"/>	Bruise Easily <input type="checkbox"/>
Ringing/Extra Noises in the Ear <input type="checkbox"/>	Belching Sour Material into Throat <input type="checkbox"/>	Masses (lumps) in Neck <input type="checkbox"/>
Ear Pain <input type="checkbox"/>	Trouble Swallowing <input type="checkbox"/>	Others (List): _____
Ear Drainage <input type="checkbox"/>	Painful Swallowing <input type="checkbox"/>	

10. ALLERGIES: Are you allergic to any of the following? Check all that apply.
 Latex Adhesive Tape Contrast Dye Iodine Seafood Metal

11. DRUG ALLERGIES: NONE

	Name of Medication	What happens when you take this medication?
1		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis
2		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis
3		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis
4		<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Anaphylaxis
5		

12. CURRENT MEDICATIONS: NONE

	Name of Medication	Strength? (mg)	How many times a day?	Reason for taking it
1				
2				
3				
4				
5				
6				
7				
8				
9	Please bring these medications	with you on your	first appointment	
10	Nasal Spray: <input type="checkbox"/> None <input type="checkbox"/> Astelin <input type="checkbox"/> Flonase <input type="checkbox"/> Nasonex <input type="checkbox"/> Nasocort AQ <input type="checkbox"/> Rhinocort Aqua <input type="checkbox"/> Afrin			

13. PAST SURGICAL HISTORY: (Include all operations that you have had)

	Name of Operation	Date	Reason	Doctor	Hospital
1					
2					
3					
4					
5					
6					

14. OCCUPATION: _____ Retired

Your pharmacy is? _____ Notes: _____

Address: _____

Phone number: _____

This form was completed by: _____ Date: _____

Relationship to patient: Self Mother Father Daughter Son Other (specify) _____

Office Policies

We are committed to providing you with the best possible care. In order to better serve you, KENTUCKY EAR, NOSE & THROAT has adopted the following policies. Please read and familiarize yourself with these policies so that future misunderstandings can be avoided. If you have questions, please do not hesitate to speak with the practice administrator.

- 1) If we participate with your insurance plan and it requires a referral, you will be held responsible to obtain a referral prior to your visit. All co-payments will be collected at the time of service. Please refer to your insurance company's provider directory to see if we participate with your plan.

*Please remember. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. You are personally responsible for any bill, or portion thereof, not paid by a third party insurance carrier or Medicare. Note: Hearing tests are frequently not covered by Medicare and other carriers.

- 2) If we do not participate with your insurance plan, you will be required to pay in full at the time of service, unless payment arrangements have been made prior to your visit. Our encounter form will serve as a receipt to submit to your insurance carrier.
- 3) We will file all third party insurances for surgical procedures. However, we will require any insurance deductibles and/or co-payments up to 20% be paid prior to the date of surgery.
- 4) For elective procedures not covered by insurance, payment in full is required prior to surgery.
- 5) A service fee of \$25.00 will be assessed for each returned check. Past due accounts may also be subject to attorney's fees, court costs, and other costs of collection.
- 6) In the event of repeatedly missed or broken appointments, the practice reserves the right to discharge a patient from its care.
- 7) For hearing aids dispensed by this office, payment in full is required when you pick up the device. You are entitled to a full refund minus the non-refundable fitting fees for up to 30 days from the time you pick up the aid.
- 8) I will allow photographs to be taken and used at the discretion of Kentucky Ear, Nose & Throat for treatment and educational purposes.

PATIENT'S NAME: _____

I have read the policies above and understand my responsibilities in exchange for medical care provided by Kentucky Ear, Nose and Throat.

Signature: _____ Date: _____

I Have Received The Privacy And Procedures Notice From Kentucky Ear, Nose and Throat.

PATIENT'S NAME: _____

Patient/Guardian Signature: _____ Date: _____