PATIENT INFORMATION

Photo I.D. and Insurance card(s) are required at every patient appointment to verify identity – per FTC guidelines.
Thank you for choosing ENT Surgical Associates! In order to serve you properly, please complete both sides of this form.
Please print clearly. ALL information is kept confidential. If the information you provide is not correct – we cannot process your claim through your insurance company. **ALL copays are due at the time of service.**

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native
☐ Multi-Racial ☐ Hawaiian ☐ Latino ☐ Other: _____

Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

Patient Employer: _____ Work Phone: _____ Ext. _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Nearest Relative (not living with patient): _____ Phone: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

Does the patient have an Advance Directive? YES or No

Referring Physician or Primary Physician: _____

RESPONSIBLE PARTY INFORMATION (If it is NOT the patient)

Name of Responsible Party: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(write same – if address is the same as the patient)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relation to patient: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

Does the patient have a Secondary Insurance to be filed? ☐ **YES** ☐ **NO**

If the answer is YES – Please complete the back of this form with the Secondary Insurance Information.
If the answer is NO – Signature is required on the back of completed form.

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SECONDARY INSURANCE INFORMATION
(ONLY IF APPLICABLE FOR PATIENT)

Name of Insured: _____ Relation to patient: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

I authorize release of any information concerning my (or my dependent's) health care, advise and treatment providing for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits payable to the insured party to be directly paid to ENT Surgical Associates of Central Georgia, PC and/or ENT Surgical Center of Central Georgia, Inc. I understand that I am financially responsible for any charges not covered by my insurance, and they are due in full upon receipt of notice. ALL information use for any purpose will be within the guidelines stated in our patient privacy policy according to HIPPA Law.

ENT Surgical Associates and ENT Surgical Center are separate facilities and are billed separately. All Claims are filed to the insurance company as a courtesy to our patient – but if the claim is denied the patient or the responsible party will be held responsible for payment(s). Any out-of-network claims for the ASC that have been paid to the insured party must be remitted immediately or the patient/insured party will be responsible for the account in full upon receipt. Signing below states you verify all information to be complete and accurate and understand our policy for insurance processing and payment(s) to our practices. The Insurance company is responsible for the patient's policy and it is a contract between the Policy holder and the Insurance Company.

_____ _____

Signature of Patient (or Parent/Guardian if patient is a minor) **Date**

PLEASE TAKE AN ADDITIONAL MINUTE TO TELL US HOW YOU HEARD ABOUT OUR OFFICE...
Select from the following list – mark/complete any that apply. Thank you for your time and help!

- FAMILY
- FRIEND _____
- MED-STOP
- EMERGENCY ROOM
- INTERNET – Search Engine _____
- ENT WEBSITE (www.entsurgical.info)
- RFERRAL FROM DR. _____
- EMPLOYEE AT ENT SURGICAL ASSOCIATES/CENTER
- YELLOW-PAGES ADVERTISEMENT
- NEWSPAPER
- OTHER: _____

COMPLETE ALL INFORMATION ON TIIS FORM AND RETURN IT TO THE RECEPTIONST.

INSURANCE CARD AND PICTURE I.D. ALSO REQUIRED –
WE CANNOT FILE A CLAIM TO THE INSURANCE WITHOUT THE INSURANCE CARD.
THANK YOU.

FORM MUST BE COMPLETED AND SIGNED OR INSURANCE CANNOT BE PROCESSED.
PAYMENT(S) REQUIRED IN FULL BEFORE APPOINTMENT WITH PROVIDER.

ENT Surgical Health History Form

First Name:_____ Middle:_____ Last:_____ Date of Birth:___/___/____

Home Phone: (___) ____-_____ Cell Phone: (___) ____-_____ Gender: ☐ Male ☐ Female ☐ Other

Review of Symptoms–Check only the ones you NOW have or have had RECENTLY, if there are no symptoms check NONE.

General	Skin	Head	Eyes	Ears
☐ Weakness ☐ Fatigue ☐ Fever ☐ Chills ☐ Night Sweats ☐ Fainting ☐ None	☐ Skin Color Changes ☐ Skin Rashes ☐ Itchy Skin ☐ Skin Sores ☐ None	☐ Headaches ☐ Head Injuries ☐ Head Lesions ☐ Head/Facial Lesions ☐ None	☐ Blurred Vision ☐ Eye Redness ☐ Itchy Eyes ☐ Burning Eyes ☐ Eye Swelling ☐ Eye Pain ☐ Dry Eyes ☐ Tearing ☐ None	☐ Hearing Loss ☐ Ringing ☐ Ear Discharge ☐ Earache ☐ Itchy Ears ☐ Loss of Balance ☐ Dizziness ☐ Room Spins ☐ Ear Blockage/ Obstruction ☐ Ear Infections ☐ Ear Lesions/Sores/ Deformity ☐ None

Nose	Mouth	Throat	Neck	Lungs
☐ Loss of Smell ☐ Nose Bleeds ☐ Nasal Pain ☐ Nasal Discharge ☐ Nasal Obstruction ☐ Nasal Congestion ☐ Snoring ☐ Post Nasal Drip ☐ Deviated Septum ☐ Runny Nose ☐ Sinus Congestion ☐ Nasal Sores/Lesions ☐ None	☐ Bleeding Gums ☐ Oral Sores ☐ Dental Problems ☐ Mouth/Jaw Pain ☐ Bad Breath ☐ Loss of Taste ☐ Dry Mouth ☐ Oral Ulcers ☐ Oral Blisters ☐ Bad Taste ☐ None	☐ Sore Throat ☐ Bad Tonsils/ Tonsillitis ☐ Hoarseness ☐ Hard to Swallow ☐ Recurrent Infections ☐ Oral White Spots ☐ None	☐ Neck Enlargement ☐ Neck Stiffness ☐ Neck Soreness/ Pain ☐ Neck Lumps ☐ Neck Masses ☐ None	☐ Cough ☐ Phlegm ☐ Coughed Blood ☐ Shortness of Breath ☐ Wheezing ☐ Pain in Lungs ☐ Chest Congestion ☐ Inhalant Exposure ☐ None

Heart	Gastrointestinal	Neurological	Psychiatric	Endocrine
☐ Murmur ☐ Palpations ☐ Rapid Heartbeat ☐ Swollen Extremities ☐ Cold Extremities ☐ Tightness/Pressure ☐ Chest Pains ☐ Varicose Veins ☐ Blood Clots ☐ Blue Extremities ☐ None	☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Abdominal Bloatedness ☐ Belching ☐ Heartburn ☐ Indigestion ☐ None	☐ Seizures ☐ Vertigo ☐ Loss of Facial Expression ☐ Weak Grip ☐ Paralysis ☐ Slurred Speech ☐ Tingling/ Burning/ Numbing ☐ Disorientation ☐ None	☐ Hyperventilation ☐ Alcohol Abuse ☐ Drug Use ☐ Drug Abuse/ Addiction ☐ None	☐ Weight Loss ☐ Weight Gain ☐ Hoarseness/ Voice Changes ☐ Hypoglycemia/ Low Blood Sugar ☐ Diabetes/ High Blood Sugar ☐ None

Medications: List all medications you are currently taking. Include ALL medications even over the counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued

List ALL Allergies	Allergic Reaction

Past Medical History – Please provide a complete history including all illnesses, injuries, hospitalizations, and operations.

List ALL Illnesses, Injuries & operations	Date	Hospital	Treatment	Physician	Response

Immunizations:

☐ DPT ☐ Measles
☐ Mumps ☐ Pneumococcal
☐ Smallpox ☐ Influenza
☐ Typhoid ☐ Polio
☐ Tetanus ☐ MMR

Has the patient listed tested **positive** for any of the following:

☐ HIV
☐ Hepatitis, if positive please list type(s): _____
☐ Other communicable diseases: _____

Last Chest X-Ray: _____
☐ Normal ☐ Abnormal
Last TB Skin Test: _____
☐ Normal ☐ Abnormal
Last EKG: _____
Last Eye Exam: _____

Family History – Please list all **Blood Relatives** with their current health status and any illnesses that they have had or have.

List Blood Relatives:	Health Status	Age if Living	Age at Death	Cause of Death	Illnesses
Father					
Mother					
Brother (s)					
Sisters (s)					

Alcohol: ☐ Never ☐ Beer(s) _____ Per week ☐ Liquor _____ Per Week ☐ Wine ____ Per Week How Many Years? _____

Smoking: ☐ Never ☐ Current ☐ Previous Packs Per Day: _____ How Many Years? _____

Caffeine: ☐ None ☐ Current ☐ Previous Cups Per Day: _____ How Many Years? _____ Other: _____

Aspirin: ☐ None ☐ Current ☐ Previous Quantity Per Day: _____ How Many Years? _____ Other: _____

Signature: _____ Date: _____

ALL INFORMATION IS REQUIRED TO BE COMPLETE AND ACCURATE. INSURANCE COMPANIES REQUEST THIS INFORMATION TO VERIFY CLAIMS THAT ARE PROCESSED. THIS FORM WILL BE UPDATED ANNUALLY.