PATIENT HEALTH HISTORY

Welcome to our practice. As a new patient please fill out the information below to the best of your ability.

PATIENT NAME: Last_____**First**_____**MI**_____

Address:_____

_____ **Phone Number:**_____

Age:_____ **Date of Birth:**_____/_____/_____ **Height:** _____ **Weight:**_____ **Gender:** ☐ **Male** ☐ **Female**

PRIMARY PHYSICIAN (Name and Phone number):

_____

PHARMACY (Name and Phone Number): _____

REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY

Have you ever had any of the following:

☐ Allergies
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Chronic Lung Disease
☐ Cancer
☐ Diabetes
☐ Glaucoma
☐ Migraines
☐ Hearing loss
☐ Heart Attack
☐ Heart Failure
☐ Hypertension
☐ Have Pacemaker
☐ HIV
☐ Heart Stent
☐ Obstructive sleep apnea
☐ Seizures
☐ Stroke
☐ Thyroid Cancer
☐ Thyroid Nodule
☐ Multiple Sclerosis
☐ Reflux
☐ Other:

_____

Any History of Cancer? Yes ☐ No ☐

Type and treatment received:_____

MEDICATIONS

Please list any medications you are currently taking (include nonprescriptions)

ARE YOU TAKING ANY BLOOD THINNING MEDICATIONS? ☐ **YES** ☐ **NO.** If yes, please mark below

Name of Medication	Dosage	Taken for (Medical Condition/Problem)

☐ Aspirin ☐ Plavix ☐ Warfarin ☐ Eliquis ☐ Pradaxa ☐ Xarelto ☐ Other: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** ☐ **NO.** If yes, please list below:

_____

SURGERIES AND HOSPITALIZATIONS

List any surgeries you have had:

_____

_____

SOCIAL HISTORY

1. What type of work/school do you do? _____
2. Who lives with you at home?

☐ Live Alone
☐ With spouse/partner
☐ With parents
☐ With other family members
☐ With friends
☐ With children
☐ In an assisted living facility
☐ Shelter
☐ Other: _____

3. Do you Smoke Tobacco?

☐ Yes, _____ packs per day

☐ Quit _____ years ago, smoked _____ packs per day

☐ Never

4. Do you vape? Yes ☐ No ☐

Start date:_____ How often do you vape?_____

5. Do you drink alcoholic beverages? Yes ☐ No ☐

How often? _____ alcoholic beverages per day/week/month (circle)

6. Do you use recreational drugs? Yes ☐ No ☐

FAMILY HISTORY

Has a family member been diagnosed with the following?

- ☐ Family History Unknown/Adopted
- ☐ Arthritis
- ☐ Blocked arteries
- ☐ Bleeding problem
- ☐ Migraines
- ☐ Heart attack/Heart Disease
- ☐ Hearing Loss
- ☐ Hypertension
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Seizure

☐ Other: _____

REVIEW OF SYSTEMS

Please mark if you now have or have recently had any of the following:

Constitutional Symptoms
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headache

Eyes
- ☐ Eye disease or injury
- ☐ Eye sensitivity to light
- ☐ Double Vision

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Earaches or drainage
- ☐ Chronic sinus problems
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands in neck
- ☐ Mouth sores
- ☐ Swollen glands in neck
- ☐ Nasal discharge
- ☐ Trouble swallowing
- ☐ Snoring
- ☐ Dizzy/off balance

Respiratory
- ☐ Cough
- ☐ Spitting up blood
- ☐ Wheezing
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest pain
- ☐ Palpitation

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding/Bruising easily
- ☐ Anemia

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Black/bloody stool
- ☐ Indigestion

Genitourinary
- ☐ Blood in urine
- ☐ Painful urination

Musculoskeletal
- ☐ Back pain
- ☐ Joint Pain
- ☐ Difficulty walking

Endocrine
- ☐ Hormone Problem
- ☐ Excessive Thirst
- ☐ Heat/Cold intolerance

Psychiatric
- ☐ Mood Swings
- ☐ High stress
- ☐ Depression

Skin
- ☐ Rash
- ☐ Change in hair or nails

☐ **I CONSENT TO ALL ELECTRONIC PRESCRIPTION TRANSACTIONS**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of patient, parent, or guardian Date

STOP!
PLEASE READ!!!!

Alpharetta ENT Specialists

FINANCIAL AND PAYMENT POLICY

INSURANCE- If you have medical insurance of which our office is a contracted provider, we will help you receive your maximum allowable benefits. In order to achieve these goals, we ask for your assistance and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with a copy of your insurance card. We are required to obtain your signature for permission to release information to your insurance carrier.

At Alpharetta ENT Specialists we participate with most insurance plans. Although we do our best to verify your insurance coverage prior to treatment, we encourage all patients to contact your insurance company to verify that we are considered an in-network, participating provider**. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE AND BENEFITS, INCLUDING PRE-CERTIFICATIONS, REFERRALS AND AUTHORIZATION REQUIREMENTS.**

SERVICES YOU MIGHT RECEIVE- Your office visit may very likely include diagnostic procedures that will assist the doctor in his evaluation of your condition. Most common of these is endoscopy, an instrument that allows visualization of your nasal anatomy; laryngoscopy, an instrument that allows visualization of your throat anatomy; nasal cautery for treatment of nosebleeds; tympanometry, to evaluate ear drum activity; ear wax removal; etc. THESE PROCEDURES ARE A ROUTINE PART OF THE DOCTOR'S EXAMINATION AND DO NOT REQUIRE WRITTEN CONSENT PRIOR TO BEING PERFORMED. Please be aware that your insurance company will process these procedures as a separate charge, and most often, at a benefit level beyond any copay you have for the office visit. If **you do not wish to have any of these procedures performed as part of your visit because of questions about cost, please notify our staff prior to seeing a doctor.**

PAYMENT FOR SERVICES- Payment for services, including co-payments, co-insurance and deductible amounts is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. Returned checks, balances over 60 days and failure to pay account balances as promised may be subject to external collection and additional fees. *Self-pay payments are due at the time of the visit.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand that we participate in many insurance plans. Your insurance is a contract between YOU and YOUR INSURANCE COMPANY. We are often not a party to that contract. We are very sensitive to keeping health care costs affordable for our patients. We must emphasize that as a medical doctor, our relationship is with you, not your Insurance company.

My signature below serves as acknowledgement and acceptance of this policy.

_____ _____

Patient (Guarantor) Date

ALPHARETTA ENT SPECIALISTS
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware Alpharetta ENT Specialists has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPAA).

As a patient of Alpharetta ENT Specialists, I understand and acknowledge the following:

- Alpharetta ENT Specialists has a privacy policy in effect in their office.
- Alpharetta ENT Specialists has made this policy available to me to review, by placing a complete version in a binder that resides in the waiting room for direct patient access as well as on our website: **Alpharettaentspecialists.com**
- Alpharetta ENT Specialists has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Alpharetta ENT Specialists and have read and understood the acknowledgement form. If you would like to obtain a copy of our privacy policy, please request one from our staff.

____ No, I do not want a copy, but understand and acknowledge that the Privacy Policy exists.
____ Yes, I do want a copy of the Privacy Policy for my personal file.

_____
Patient Signature (Guardian if patient is a minor)

I authorize the following individuals to have full access to my health information:

_____	_____	_____
Print Name	Relationship	Date
_____	_____	_____
Print Name	Relationship	Date

I, _____give my permission for you to leave any medical/lab information for me at the following phone numbers:

Home #: _____
Mobile#: _____
Work#: _____