

PATIENT INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. *Thank you!*

PATIENT INFORMATION

Name (First, Middle Initial, Last) _____

Date of Birth: _____ Age: _____ Sex: Male / Female Marital Status: S M W D

Address: _____

City: _____ State: _____ Zip Code: _____

Home: () _____ Work: () _____ Alternate: () _____

Social Security Number: _____

Employer: _____

Employer Address: _____

Referring Physician: _____ Primary Care Physician: _____

RESPONSIBLE PARTY

(Please give the information for the person who is, the policyholder of the insurance or if the patient is a child please give the information for the person who is the responsible for financial issues.)

Name: _____ Relationship to Patient: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Employer Address: _____

Home Phone Number: () _____ Work Number () _____

IF PATIENT IS A CHILD

Parent/Guardian 1 _____ Daytime Contact: () _____

Parent/Guardian 2 _____ Daytime Contact () _____

LOCAL EMERGENCY CONTACT

Contact Name: _____

Relationship: _____ Daytime Contact: () _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I hereby assign payment directly to Carolina ENT, PLLC of the surgical medical and/or major medical benefits, if any, otherwise payable to me for the professional services rendered in the course of any examination of treatment. This authorization shall remain valid until revoked in writing.

Signature: (Insured)

Date

RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES

I understand that Carolina ENT, PLLC will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care. Should my insurance deny for any such reasons as; an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill.

Signature: Patient or Responsible Party if Patient is a Minor

Date

NOTICE OF PRIVACY PRACTICES

I understand that Carolina ENT’s Notice of Privacy Practices informs me of how my medical information may be used pertaining to treatment, payment and healthcare operations. My signature signifies that I have received a copy of this notice.

Signature: Patient or Responsible Party if Patient is a Minor

Date

03/10/04

In order to better serve our patients, their families and comply with federal government's privacy act, we ask that you list below who you give Carolina ENT permission to discuss your medical information with:

Name Relationship

Name Relationship

Name Relationship

If at any time you decide to add/remove anyone from this list, you will need to contact us in writing or in person.

Patient History

Date Updated

Signature

Today's Date: _____

Name: _____ Age: _____

Medical Physician: _____

Referred by (i.e. doctor, friend, telephone book, Internet): _____

Chief Complaint (reason for today's visit): _____

Any associated symptoms? _____

Past Medical Problems (i.e. high blood pressure, diabetes): _____

Previous Surgeries: _____

Family History of Medical Problems: _____

Do You Smoke? Y N

If yes, how much? _____

If you quit, when did you stop? _____

Do You Drink Alcohol? Y N

If yes, how much? _____

If you quit, when did you stop? _____

Caffeine Intake Daily: _____ (coffee, tea, colas)

Occupation: _____ (if retired, please list previous occupation)

Drug Allergies (which medicines and what reaction?): _____

Medications (include dosages): 1. _____ 2. _____

3. _____ 4. _____ 5. _____

6. _____ 7. _____ 8. _____

9. _____ 10. _____ 11. _____

Review of Systems (Do you *currently* have any of the following problems): Yes No If yes, please explain

Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye problems (e.g. double vision, eye injuries)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat, heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine, kidney stones)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, skin cancer, keloids or excessive scarring)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g. numbness, weakness, headaches, migraines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV, AIDS, TB, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature: _____