PATIENT INFORMATION

PLEASE PRESENT INSURANCE CARD/S WITH THIS FORM

Patient's Name (FIRST) _____ M.I. _____ (LAST)_____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

S.S. #_____

DOB _____/_____/_____

Primary Phone _____ (Home/Business/Cell)

Secondary Phone _____ (Home/Business/Cell)

Preferred Method of Contact for Appointment Reminders - Text Message//Phone/Other

Gender - Male/Female

Race – White/Black or African American/American Indian/Asian/Native Hawaiian/Hispanic/Other

Marital Status: Married/Single/Divorced/Widowed

Ethnicity - Hispanic or Latino Not Hispanic or Latino Declined to Provide

Employment _____ Employer Phone No._____

Emergency Contact _____ Relationship _____

Emergency Phone No. _____

SPOUSE NAME _____ SPOUSE D.O.B_____

Referring Physician _____

How did you hear about us? Billboard Sign Friend Internet Newspaper Referring Physician
Bluffs and Bayous Magazine Radio Ad Telephone Book

Payment Policy:

- **Surgery Fee –** A deposit of $250.00 must be paid **prior** to patient's surgery date.
- **Excision Fee** – A deposit of $150.00 must be paid at time of service.
- **Office Fee/Co-Pay** – Insurance Co-Pays are due at time of service and payment in full is required for all other services.

Assignment of Benefits • Financial Agreement • Authorization to Release Information

I hereby give lifetime authorization to any physician, nurse practitioner, hospital, or medical care facility to provide information to Brookhaven ENT Allergy & Facial Surgery for the furtherance of my health care services.

I hereby agree to be responsible for the payment of the patient's account. If not paid when due, I will be responsible for any collection fees and/or attorney fees to collect this account. Our office will file primary and secondary insurance as a courtesy. However, we do not file secondary insurance for allergy injections.

I request that payment of authorized insurance benefits be made either to me or on my behalf to BROOKHAVEN EAR, NOSE & THROAT CLINIC for any services furnished me by that physician/provider. I authorize any holder of medical information about me to release to BROOKHAVEN EAR, NOSE & THROAT CLINIC and its agents any information needed to determine these benefits or the benefits for related services.

_____ _____

Signature of Patient/Guardian Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (TPO)

Signing this consent allows our office to use and disclose your Protected Health Information for Treatment, Payment, or Health Care Operations (TPO). Signing this consent also establishes a written acknowledgement that the **Notice of Privacy Practices for Protected Health Information** has been presented to and/or received by you.

_____

Signature of Patient or Parent or Legal Representative

_____

Name of Patient (Please Print)

_____

Date

Please list any other person(s) whom we may discuss health information and/or payments regarding your account with Brookhaven Ear, Nose & Throat Clinic.

_____ _____

Phone No. _____ **Phone No.** _____

May we leave a message on your answering machine or cell phone voice mail? _____Yes _____No

Ryan C. Case, MD
Otolaryngology/Head and Neck Surgery
Board Eligible
Carol A. Buckels, CFNP
Certified Nurse Practitioner
Lesleye L. Smith, CCC-A
Audiologist

Adult Med History

Diseases of the Ears, Nose and Throat—Allergies
Head and Neck Surgery—Facial and Plastic Reconstructive Surgery
Specializing in the Diagnosis and Treatment of Nasal and Sinus Problems

Name_____ Date of Birth_____

Drug Allergies_____ Pregnant/Nursing? Y/N

Reason For Visit_____Referring MD_____

Do you have any medical problems other than reason for visit today?
Such as: ___Heart Disease ___High Blood Pressure ___Lung Disease___ Diabetes ____HIV/AIDS___ Dialysis ___Bleeding Disorders ____Cancer Type:_____
If others please list:
_____

Have you been Hospitalized? Y/N Please explain when and why.
_____

Do you have trouble with nasal or eye allergies or asthma? Y/N
Have you ever been allergy tested? Y/N, If so, when?_____

Do you get frequent sinus infections? Y/N How many in the past year? _____
Have you had sinus surgery? Y/N_____

Do you have concerns about your hearing? Y/N

Have you ever had any skin cancers or skin lesions? Y/N
If so when & where were they treated?_____

What surgery have you had and when was it performed?
_____
_____

Do any diseases run in your family? (Circle) Allergies, Hearing Loss, Thyroid. If others please list:
_____

Do you smoke? Y/N How many packs per day?_____ For how many years?_____

Do you drink more than socially? Y/N How many drinks per day? _____

Are you in school, working, retired, or disabled? (circle one)

How did you find out about us? (Circle One) Web site, Facebook Page, Newspaper, Billboard, Radio, TV, Bluffs and Bayous, Referring Doctor, Friend

Do you have any questions about the cosmetic skin care services we offer? Y/N

Name:_____

Medication History

Allergies to medications/other:

_____

_____

Current Medications:

Name:	**Dosage:**	**Frequency:**

Pharmacy:

1st Choice:_____

2nd Choice:_____