Patient Intake Form

Date: ____________________

Last Name: _____________________________ **First Name:** ____________________________ **MI:** _______________________

Date Of Birth: ____/____/____ **Preferred Name:** _____________________

Previous Name (If Applicable): ________________________

Address: ____ **City:** _________________________________

State: ______________ **Zip:** _____________ **Sex: M / F OR Gender Identification (If Applicable):** ___________________

Home Phone: (_____) ____________ **Cell:** (_____) ____________ **Work:** (_____) __________________ **ext:** _______________

Email Address: ________________________ **(If patient is a minor, please list a parent or guardian email address.)**

SSN: ___________________________ **Marital Status:** ____________________ **Employer:** _____________________________

Languages: ☐ English ☐ Sign Language ☐ Spanish; Castilian ☐ Other (Please Specify): ________________________

Primary Care Physician: ______________________________ **Phone Number:** (_____) ______________________________

Referring Physician: __________________________________ **Phone Number:** (_____) ______________________________

***Emergency Contact:** _________________________________ **Relationship to Patient:** _____________________________

***Emergency Contact Phone Number:** (_____)____

Primary Insurance Information:

Plan Name: ______________________________________

Subscriber Name (if not self): ___________________

Relationship: ___________________________________

Employer: _______________________________________

Subscriber DOB: __________________________________

Secondary Insurance Information:

Plan Name: ____

Subscriber Name (if not self): ___________________________

Relationship: ____

Employer: ____

Subscriber DOB: ____

****If the patient is a MINOR****

Please list the parent(s)/guardian(s) information:

Last Name: ______________________________ **First Name:** ______________________**Date Of Birth:** _____/_____/_____

Employer: _______________________________ **Relationship to Patient:**__________________ **Responsible Party:** Y / N

Best Contact #: (_____) _______________________ **Work #:** (_____) ________________________

Last Name: ______________________________ **First Name:** ______________________**Date Of Birth:** _____/_____/_____

Employer: _______________________________ **Relationship to Patient:**__________________ **Responsible Party:** Y / N

Best Contact #: (_____) _______________________ **Work #:** (_____) ________________________

Please list any other individuals that have your permission to seek medical treatment/services for your child:

Name: ______________________ **Relationship:** ____________________ **Phone Number:** (_____) ________________

Name: ______________________ **Relationship:** ____________________ **Phone Number:** (_____) ________________

Name: ______________________ **Relationship:** ____________________ **Phone Number:** (_____) ________________

Signature: ____________________________ **Date:** ___________________

Medical Records Release, Financial Policy, and Receipt of Privacy Notice

I authorize the release of any medical or other information necessary to process a claim for medical related services provided to the patient. I also request payment of all medical benefits, including government benefits, to the attending physician. I understand that I am financially responsible to the physician for charges not covered by the patient's insurance. All copayments, coinsurance, and payment for services not covered by the patient's insurance policies are expected at the time of service. Please allow the receptionist to copy all insurance cards for our files.

Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk of any changes in insurance coverage or when the claim should be billed to a Medpay (auto insurance), liability insurance company, or worker's compensation company rather than your regular primary insurance due to cause for treatment. We will file your insurance claims for you unless you instruct us otherwise.

All copayments, deductibles, coinsurance, and payment for services not covered by the patient's insurance policies are the responsibility of the patient and may be expected at the time of service. If you have Medicare and you receive a service that Medicare may deem as "medically unnecessary," according to HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and will be responsible for payment at the time of service.

We are obligated under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at the time of service or who repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your healthcare benefits. You may contact your employer's human resources department for further clarification of your benefits and obligations.

If you make an overpayment on your account for a particular service, a refund will only be issued if there are no other outstanding debts on your account or on any other account containing the same guarantor or financially responsible party. Patient balances unforeseen at the time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone, or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Once an account has been turned to a collection agency, we are not at liberty to arrange a payment plan with you.

Failure to meet your financial obligations may result in reporting you to the credit bureau, filing for a judgment in small claims court, or other collection action against you. You may also be terminated as a patient of ENTCET. All attorney fees, court costs, and other expenses related to collecting your account will be added to your outstanding balance. A $25.00 service charge may be added for each returned check.

Should you be unable to make it for your surgery or in office procedure for any reason, our office requires at least a 48-hour notice. If we are not notified, you COULD be subject to a $100.00 NO SHOW FEE.

I acknowledge that ENTCET made available to me its Notice of Privacy Practices dated 9/23/13.

I have read, understand, and will comply with ENTCET's Financial Policy above.

Signature: ______________________________

Print Name: ______________________________

Date: ______________________________

Ear, Nose and Throat Consultants of East Tennessee

History and Physical

Date: ______________________ **Chart Number:** ______________________
Name: ____
Age: __________ **Date of Birth:** __________ **Height:** __________ **Weight:** __________

Drug allergies: Yes / No If yes, list all:

Pharmacy Name/Number: ____________

Circle all Prior Surgeries:

Heart Surgery
Sinus Surgery
Ear Surgery
Back Surgery
Tonsillectomy
Other:

Gallbladder Removal
Appendectomy
Hernia Repair
Skin Cancer Removal
Adenoids Removed
Ear Tubes

Family History: Any Significant Illnesses?

Mother:	**Father:**	**Siblings:**
________	________	________
________	________	________
________	________	________

Diabetes	Y / N
High Blood Pressure	Y / N
Heart Attack/Coronary Artery Disease	Y / N
Arrhythmia	Y / N
Cancer	Y / N
Stroke	Y / N
Arthritis	Y / N
Bruising/Bleeding	Y / N
Sleep Apnea	Y / N
CPAP User	Y / N
Claustrophobia/Anxiety	Y / N
Dementia	Y / N

Other Health Problems: ____

Primary Care Provider: ____

Social History:
Tobacco Use:
Have you ever smoked? **Yes / No** **Packs/day**___
How Long ________
If quit smoking, how long ago? ________
Alcohol Use: ___drinks/ ____day, ___wk, __month

Review of Systems: Please circle any problems you are presently experiencing or have previously experienced:

Good Health Yes / No
Recent Weight Change
Fatigue
Hearing Loss
Ringing in Ears
Earache or Drainage
Nose Bleeds
Sore Throt
Snoring

Shortness of Breath
Cough
Chest Pain
Neck Stiffness
Dizziness
Difficulty Swallowing
Vocal Hoarseness
Sinus Problems

Mouth Sores
Dental Problems
Painful Breathing
Spitting up blood
Seizures
Numbness
Enlarged Lymph Nodes
Bad Breath or Bad Taste

Medications: Please list all medications you are taking, including over-the-counter medication:

Medication:	**Dosage:**	**How Often:**	**Who Prescribed:**	**(In Office Use)**

Ear, Nose and Throat Consultants of East TN.

Consent for Healthcare Information

I ____, give permission to ENTCET to disclose my healthcare information to the following parties: (Please list all parties, including yourself if the patient is a minor, that we may discuss this information with.)

Please give full names.

Name: ____ **Relationship:** ____________________________________

Name: ____ **Relationship:** ____________________________________

Name: ____ **Relationship:** ____________________________________

WHERE AND HOW MAY WE CONTACT YOU? (This includes leaving a message/voicemail.)

HOME ☐ **YES** If yes, please provide home phone number

☐ **NO** _______________________________________

WORK ☐ **YES** If yes, please provide work phone number

☐ **NO** _______________________________________

CELL ☐ **YES** If yes, please provide cell phone number

☐ **NO** _______________________________________

EMAIL ☐ **YES** If yes, please provide email address

☐ **NO** _______________________________________

Can we send you appointment reminders via text message? ☐ **YES** ☐ **NO**

If YES, please provide the preferred number we should send your appointment reminder text to:

____

Signature: ____ **Date:** ____________________________________