PATIENT INFORMATION

Last Name:____________ First Name:____________ Middle Name:____________ Maiden Name:____________

Age:____________ Birthdate:____________ Cell Phone:____________ Home Phone:____________

Marital Status S M D W Sex:____________ Social Security No:____________

Address:____________ City:____________ State:____________ Zip:____________

Occupation:____________ Place of Employment:____________ Work Phone:____________

Employer's Address:____________ City:____________ State:____________ Zip:____________

Full Name of Patient's Spouse:____________ Social Security No:____________ Employer:____________

Address (if different):____________ City:____________ State:____________ Zip:____________

Birthdate:____________ Cell Phone:____________

Person to Notify in Case of Emergency (outside of your home):

Name:____________ Relation:____________ Phone No.:____________

RESPONSIBLE PARTY (if the patient is a child or dependent)

Father's Name:____________ Birthdate:____________ Social Security No.:____________

Father's Address:____________ City:____________ State:____________ Zip:____________

Father's Employer and Address:____________ Phone:____________

Mother's Name::____________ Birthdate:____________ Social Security No.:____________

Mother's Address:____________ City:____________ State:____________ Zip:____________

Mother's Employer and Address:____________ Phone:____________

PRIMARY INSURANCE

Company:____________

Policy Number:____________

Group Number:____________

Policy Holder's Name:____________

Policy Holder's Place of Employment:____________

SECONDARY INSURANCE

Company:____________

Policy Number:____________

Group Number:____________

Policy Holder"s Name:____________

Policy Holder's Place of Employment:____________

PLEASE TURN OVER AND COMPLETE THE BACK SIDE

INITIAL HISTORY FORM

NAME: ______________________ AGE: __________ DATE: ______________

REASON FOR VISIT: ______________________ DURATION: ______________
(PLEASE BE SPECIFIC)

PLEASE CHECK ( ) THE PROBLEMS THAT APPLY TO YOU:

REVIEW OF SYSTEMS

___Hearing Loss; Gradual___/Sudden_____
___Ear Infection________Number per year
___Ear Noises
___Dizziness/Vertigo
___Difficulty Understanding
___Noise Exposure
____
(Type: guns, machinery, etc.)
___Family History of hearing loss
___Nasal Stuffiness/Blockage
___Sneezing
___Snoring
___Hay Fever
___Sore throats___Number per year
___Hoarseness
___Mouth breathing
___Cough
___Spitting up blood
___Wheezing
___Shortness of Breath
___High Blood Pressure
___Palpitations
___Swollen Ankles
___Heart burn
___Headache
___Ear Itching
___Ear Stopped Up
___Ear Pain
___Runny Nose
___Sinus Pressure
___Sinus Pain
___Nausea/Vomiting
___Diarrhea
___Rash
___Pain with Urination
___Weight Loss
___Weight
___Jaundice

___Free Bleeder
___Bruise Easily

SOCIAL HISTORY -Have you ever....?
___Smoked ______ packs per day_____year Quit Y N
___Drank Alcohol____________amount Quit Y N

Marital Status: S M D W

Occupation: ______________________

FAMILY HISTORY WHO?
___Allergy ______________
___Heart Disease ______________
___High Blood Pressure ______________
___Cancer ______________
___Anesthesia Problems ______________
___Bleeding Disorders ______________
___Muscular Dystrophy ______________
___Diabetes ______________
___Seizures ______________
___Sickle Cell ______________
___Ear Disease ______________
(tubes, inner ear, etc.)
___Other__________ ______________

Mother Alive________ Deceased__________Age_____
Cause__________________
Father Alive________ Deceased__________Age_____
Cause__________________

PAST HISTORY

___Glaucoma ___Heart Failure
___Seizures ___Stroke
___Arthritis ___Kidney/Bladder
___Asthma ___Rheumatic Fever
___Ulcers ___Prostate
___Hiatal Hernia ___Migraine
___Hepatitis ___Sickle Cell
___Diabetes
___Thyroid
___High Blood Pressure
___Heart Attack
___TB
___Blood Transfusion___Date
___Other

PREVIOUS SURGERIES (List All)
Type and Date: ______________________
____
____
____
____

MEDICATIONS NOW TAKING (include OTC & Aspirin):
Type and Dose: ______________________
____
____
____
____
____

DRUG ALLERGIES: Type and Reaction
____
____
____
____
____
____

Did another physician tell you to see Dr. Long?
Doctor's Name______________________

Who is your regular medical doctor?
____

What pharmacy do you use? ______________________
Phone Number: ______________________
Location: ______________________

Shoals Ear, Nose, & Throat Group, P.C.

Patient Consent Form

Use and disclose of Protected Health Information

Shoals Ear, Nose, & Throat Group, P.C., may use and disclose my protected health information to carry our treatment, payment, and health care operations ("TPO"). I have received a copy of the PC's Notice of Privacy Practices, which provides additional information regarding such uses and disclosures.

This is my consent for the PC to:

- Call my home or other designated location and leave a message on my voicemail to remind me of appointments, obtain insurance information, notify me of my clinical care, lab results, and other test results, or other matters that may assist the PC in carrying out TPO.

- Send mail to my home or other designated location regarding matters that may assist the PC in carrying out TPO, such as appointment reminder cards, patient statements, etc.

I understand that I have the right to restrict how the PC will use and disclose my health care information. I understand, however, that the PC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. If I wish to restrict certain uses and disclosures, I must notify the PC's Privacy Officer in writing.

By signing this consent form, I am consenting to allow the PC to use and disclose my protected health information for treatment, payment, and health care operations, this also includes your pharmacy.

I understand that I may revoke this consent in writing except to the extent that the PC has already made disclosures and relied upon my prior consent. If I do not sign this consent, the PC may decline to provide treatment to me.

Please list below any person(s) that we may speak with regarding your medical care, test results, appointment reminders, etc.

Name	Relationship
Name	Relationship
Patient's Signature	Date
Signature of Parent or Guardian	Date
Print Name	Date

I would like to be reminded for appointment by:

Text Message __ Cell Phone Carrier _________ Phone Call __

AGREEMENT TO PAY

The patient/responsible party agree(s) to pay in full all charges submitted by Shoals Ear, Nose & Throat Group, P.C. ("P.C.") during patient treatment, including treatment rendered during hospitalization, unless P.C. is legally obligated to accept payment for those charges solely from a third party. The patient/responsible party agree(s) to be fully financially responsible to the P.C., even though there may be insurance or other third party coverage, or even though the charges may exceed the amount reimbursed by insurance. In the case of HMO's or other third party requiring specific referral authorization prior to making payment, patient acknowledges and agrees that any service rendered without the patient supplying the referral authorization will be considered a self-referral, for which the patient/responsible party will be solely responsible for payment. Patient/responsible party acknowledges that payment is due at the date of service, and agrees to pay a 1.5% per month late charge all unpaid balance of the account over (60) days past due. Patient/responsible party agree(s) that failure to make payment when due is the cause for legal action, and agree(s) to pay any and all costs of collection, including reasonable attorneys, and agree(s) that their obligations are joint and severable, permitting the P.C. to pursue either or both for payment.

AUTHORIZATIONS

The patient/responsible party understand(s) that the following authorizations are to be used by the P.C. and "All Physicians and Nurse Practioners" associated therewith to effect the collection of benefits in patient's behalf. These authorizations become effective on the date the first service rendered, and remain in effect until specifically revoked in writing by patient/responsible party. Copies of this agreement are to be as valid as the original.

The patient/responsible party authorize(s) the release and disclosure of any and all medical information related to patient's treatment and care to any entity, which is, or may be liable, for physician charges, or to any professional review organization associated therewith. The patient/responsible party authorize(s) the release and disclosure of all or any part of patient's medical records to any part of patient's medical records to any healthcare provider who may be of assistance, in opinion of P.C., in providing medical care and treatment for the patient, and/or for assistant in any reimbursement of benefits to which patient may be entitled.

The patient/responsible party authorize(s) and requests that payment of any authorizes insurance benefits be made either to patient, or on patient's behalf to P.C., for the services furnished the patient by the physicians and nurse practitioners of P.C. This authorization allow the P.C. to file "assigned" claims only for the purpose of having benefits paid to the P.C., and does not imply that the P.C. accepts insurance as payment in full, unless the P.C. has a contractural agreement with patient's carrier. The signatures below are deemed sufficient for all insurance forms on a continuing basis.

The signature below serves as authorization for services rendered by Shoals Ear, Nose, and Throat, P.C. for the above named patient, and serves as authorization for the release of information necessary to file insurance claims and assign benefits otherwise payable to the policyholder or group indicated on the claim or request for payment. **I understand that I am financially responsible for balances not covered by my insurance carrier and that a copy of any signature is as valid as the original.**

______________________________ ______________________________

DATE SIGNATURE