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PERIMETER | Ear Nose Throat

PATIENT INFORMATION

Date: _____ ☐NEW PATIENT ☐UPDATE

Patient: _____ _____ _____ _____ _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

Patient Date of Birth: _____ Phone: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____ _____ _____
CITY STATE ZIP CODE

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person.

_____ _____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer :_____ Occupation: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____ _____ _____
CITY ST ZIP CODE

WORK: _____X____
DIRECT: _____
OTHER: _____
PAGER: _____
FAX: _____

E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____ _____ _____ _____ _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____
_____

_____ _____ _____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

PERIMETER Ear Nose Throat

Name_____ **Age** _____ **Date of Birth** _____

Referring Physician _____ **Primary Physician** _____

Please name the major problem or symptom that brings you to us today:

Please describe the history of your illness in detail: (location, severity, timing, duration, modifying factors, coexisting factors)

_____

_____

What medications have you tried? _____

Please check those symptoms below which apply to you:

☐ Severe headache	☐ Post-nasal drip	☐ Ear pain	☐ Difficulty swallowing
☐ Failing vision	☐ Frequent sneezing	☐ Ear drainage	☐ Heartburn
☐ Eye pain/Double vision	☐ Nasal obstruction	☐ Ear fullness/pressure	☐ Can't clear throat
☐ Eyes crust/drain	☐ Nosebleed	☐ Dizzy/ off balance	☐ Cough
☐ Nasal congestion	☐ Loss of smell/taste	☐ Snoring	☐ Hoarseness
☐ Facial pain	☐ Hearing loss	☐ Stop breathing during sleep	☐ Neck mass/swollen glands
☐ Nasal discharge	☐ Ringing in ears	☐ Sleepy in the daytime	☐ Rash

Review of Systems: Please check those symptoms below which apply to you:

☐ Fever/Chills/Night sweats	☐ Wheezing	☐ Problems with urination	☐ Depression
☐ Weight loss	☐ Cough up blood	☐ Painful/swollen joints	☐ Mood swings
☐ Chest pain	☐ Nausea/Vomiting	☐ Weakness	☐ Cold/Heat intolerance
☐ Irregular heartbeat	☐ Bloody stool	☐ Shaking/Tremor	☐ Frequent thirst
☐ Shortness of breath	☐ Diarrhea	☐ Fainting	☐ Prolonged bleeding
☐ Anemia/ Bruise Easily	☐ HIV Risk Factors	☐ Exposed to Cats	☐ Exposed to Dogs

Past Medical History: Please check those symptoms below which apply to you:

☐ Glaucoma/Cataract	☐ Reflux	☐ Low thyroid	☐ Home oxygen
☐ High blood pressure High	☐ Hiatal hernia	☐ Overactive thyroid	☐ Diabetes-diet control
☐ Past heart attack	☐ Hepatitis A/B/C _____	☐ Thyroid Nodule	☐ Diabetes-oral meds
☐ Past stroke	☐ Fibromyalgia	☐ Thyroid cancer	☐ Diabetes-insulin
☐ Blocked arteries	☐ Arthritis	☐ Seizure disorder	☐ Food allergy
☐ Heart failure	☐ Head Injury	☐ Parkinson's disease	☐ Contact allergy
☐ Mitral valve prolapse	☐ Psychiatric problems	☐ Emphysema	☐ Inhalant allergy
☐ Past bypass/angioplasty	☐ Use aspirin	☐ Asthma	☐ Previous allergy test
☐ Have pacemaker	☐ Use other blood thinners	☐ Tuberculosis	☐ Bleeding disorder
☐ Other:_____	☐ Other: _____	☐ Pneumonia	☐ HIV positive

Family History: Please check those illnesses that are present in your immediate blood relatives (parents, children, siblings):

☐ Heart attack/ disease	☐ Allergies	☐ Thyroid problems	☐ Sickle cell/trait
☐ Blocked arteries	☐ High blood pressure	☐ Cancer	☐ Bleeding problem
☐ Past stroke	☐ Diabetes	☐ Hearing loss	☐ Asthma

Social History:

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

Do you or have you smoke or use tobacco products in any form? ☐YES ☐NO If yes,

Cigarette/E-Smoke/Cigar/Chewing _____ Packs/day Quit? _____ Years Smoked _____packs/day

Exposed to Second hand smoke? ☐YES ☐NO How many years?_____

DO YOU CONSUME:

Alcoholic Beverages	☐YES	☐NO	_____/day/week/month (circle)
Caffeine (coffee/tea/soda)	☐YES	☐NO	_____ Beverages per day
Water	☐YES	☐NO	_____ Glasses per day

Is there any chance you may be pregnant? ☐YES ☐NO If yes, how many weeks: _____

Have you had a Pneumonia vaccination? ☐ YES ☐NO Date: _____

Have you had a Flu vaccination? ☐YES ☐NO Date: _____

Height: _____ Weight: _____

Surgical History: Please list all prior surgical procedures

Operations	Date	Operations	Date

MEDICATION

Include vitamins, supplements, herbals

☐ I consent to ALL Electronic Prescription Transactions.

Name	Dosage

ALLERGIES

List allergies and bad reactions to medications

☐ Latex Allergy

Allergen	Reaction

Pharmacy Name and Phone Number: _____

_____ _____

Patient Signature **Date**

PERIMETER Ear Nose Throat

Financial Responsibility

Copayments _____ (Initial)
All office visits require a copayment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post operative visits.

Deductible _____ (Initial)
A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service.
An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a copayment is required for the visit. In addition, some services and all procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company and are billed as surgery.

Diagnostic Procedure Consent ____ (Initial)
Your visit today may include a scope being place in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an **INVASIVE OR SURGICAL PROCEDURE**. Depending on the specifics of your particular policy, your insurance carrier will pay all, part, or none of the cost of this procedure. It is the responsibility of you, the insured, to be aware of the limits of coverage prior to this procedure. Any charges not covered by the insurance carrier will be the responsibility of the patient. **YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.**

No Show ____ (Initial)
Patients who fail to show for their scheduled appointment, procedure, or surgery or did not notify the office within 24 hours prior to the appointment, shall be subject a No Show penalty of $25.00 for missed appointments, $150.00 for office procedures, and $150.00 for surgery.

Guarantee of Payment for Services & Assignment of Benefits ____ (Initial)
It is the policy of the office that you must pay for services when rendered except in cases of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, copayments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections.
I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of this claim.

Insurance Coverage ____ (Initial)
I understand that my eligibility for coverage by _____ has not been verified at the time of my appointment, but I want to receive medical services from Dr. _____.

I am aware that when the insurance is finally verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver ____ (Initial)
I understand that if the Referral from the Primary Care Physician's Office is not received before my appointment date, I agree to pay for all services rendered on the day of the visit

Billable items on a requested basis-list include but are not limited to:

- $25.00 for completion of all forms including Disability, FMLA, Life Insurance or other miscellaneous administrative forms required by third parties other than your insurance company
- Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at the time of request.

_____ _____
Signature (Guardian if patient is a minor) **Date**

Perimeter ENT, LLC
Privacy Policy Acknowledgement Statement

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

As a patient of Perimeter ENT, I understand and acknowledge the following:
1. Perimeter ENT has a privacy policy in effect in their office.
2. Perimeter ENT has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. Perimeter ENT 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.
4. In an effort to improve patient quality care and safety, I authorize Perimeter ENT to receive my medication prescription history from my pharmacy.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Perimeter ENT and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.

___No, I do not want a copy, but acknowledge the Privacy Policy exists.
___Yes, I do want a copy of the Privacy Policy

_____
Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, Perimeter ENT will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize Perimeter ENT to contact me in the following ways (check those which you authorize):

_____ Home phone ----------_____Voicemail OK
_____ Work phone ----------_____Voicemail OK
_____Cell phone ----------_____Voicemail OK
_____Fax _____ Text OK

_____E-Mail Email Address:_____

I understand that Perimeter ENT will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize Perimeter ENT to discuss matters related to my condition/care with the following:

_____ _____
(Please Print) Relationship to patient

_____ _____
(Please Print) Relationship to patient

_____ _____
Patient Signature (Guardian if patient is a minor) Date