INTERCOUNTY AUDIOLOGY
and Hearing Aid Center

OTOLARYNGOLOGY PLASTIC SURGERY ASSOCIATES

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Welcome to our practice.

We look forward to aiding you with your healthcare needs. To help us be prepared for your visit, please complete all of the attached paperwork *prior to* your upcoming appointment. Our goal is to have this information entered in your medical record before you see the doctor so that your visit is as efficient and effective as possible.

Please complete all forms and send them back to our office, if time allows (no less than 7 days prior to your appointment). You may also fax your paperwork, with a cover sheet to 215-348-7416. If time does not allow and you cannot fax, please bring the completed paperwork with you to your visit. If you must bring the paperwork with you we request that you arrive 15-20 minutes early so that the information can be entered into your medical record.

If you have had testing or procedures done at any facility beside Doylestown Hospital or Grand View Hospital you will need to bring a copy of the report with you. If you have had a CT Scan of your sinuses please bring a copy of the disc with you for review by the doctor.

If your insurance requires a referral to be seen, you must call and request it from your Primary Care (family) Doctor. Your doctor may require 48-72 hours to process your request.

Due to changes in law and for your protection, we will be taking your picture for identification at the time of your visit and asking you to acknowledge your HIPAA rights with a signature.

We realize all of this paperwork takes time and we appreciate your thoroughness.

Sincerely,

Otolaryngology Plastic Surgery Associates, PC

Doylestown: Doylestown Pointe, 103 Progress Drive, Suite 200 Doylestown PA 18901
Lansdale: North Penn Medical Arts Center, 2100 North Broad Street Lansdale PA, 19446
Sellersville: The Summit, 920 Lawn Avenue, Suite 7, Sellersville, PA 18960

www.ent-drs.com

CURRENT PROBLEM AND PAST MEDICAL AND SOCIAL HISTORY FORM

Please return completed form to the front desk. NO PENCIL PLEASE. Thank you.

NAME _____
(last) (first) (middle initial)

ADDRESS _____
_____
_____

E-Mail _____
(use of email internal only may use to give office updates)

PERMITTED TO DISCLOSE MEDICAL INFORMATION TO:
NAME: _____
☐ SPOUSE ☐ PARENT ☐ CHILD (OVER 18) ☐ OTHER

COMMENTS _____

_____
(Permission given per electronic signature)

DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

RACE: (Please circle)

White
Black/African American
American Indian/Alaska Native
Asian
Native Hawaiian/Other Pacific Islander
Unknown

ETHNICITY: (Please circle)
Spanish/Hispanic Origin
Not of Spanish/Hispanic Origin
Unknown

LANGUAGE _____

TELEPHONE (home) _____
(work) _____
(cell) _____

REFERRING DOCTOR _____
PRIMARY DOCTOR _____
OTHER TREATING DRS _____
_____

MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

SEX ☐ M ☐ F ☐ Other

INSURANCE INFORMATION:
Subscriber ☐ **SELF**
Complete if OTHER THAN SELF
NAME _____ DOB _____

INSURANCE CO _____
ID NO _____
GROUP NAME AND NO. _____
_____
Someone other than you to send bills to after Insurance Processing _____
ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER INSURANCE PLANS, PLEASE LIST
_____
ARE YOU A FULL-TIME STUDENT? ☐ Yes ☐ No

ARE YOU EMPLOYED? ☐ Yes ☐ No
EMPLOYER NAME _____

☐ CHECK IF HOSPICE

HOW DID YOU HEAR ABOUT US? _____
_____

HAVE YOU OR ANY FAMILY MEMBERS BEEN PREVIOUSLY SEEN BY THE DOCTOR? _____

ALLERGIES? ☐**Yes** ☐**No**

	Type of Reaction		**Type of Reaction**

Have you ever had an allergy test? ☐Yes ☐ No
Have you ever taken allergy shots? ☐ Yes ☐ No If yes, are you still taking them? ☐ Yes ☐ No
How much relief from shots? ☐ Minimal ☐ Partial ☐ Significant
Latex Allergy? ☐ Yes ☐ No

LIST ALL MEDICATIONS YOUA RE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	**Dosage**	**How often taken**	**Medication**	**Dosage**	**How often taken**

Patient Name: _____ DOB: _____

PHARMACY NAME (include phone number and address if known)

***MEDICAL/SURGICAL CURRENT PROBLEM AND HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

Surgery/Management

Cardiovascular:

Coronary Artery Disease ☐ **Yes** _____

☐ **Heart Attack**

Elevated cholesterol (hyperlipidemia) ☐ **Yes** _____

High Blood Pressure (hypertension) ☐ **Yes** _____

☐ **Stroke**

Gastrointestinal:

Hepatitis ☐ **Yes** _____

Gastroesophageal reflux ☐ **Yes** _____

Genitourinary:

Renal Failure (acute) ☐ **Yes** _____

Ear/Nose/Throat: (HEENT)

Cataracts ☐ **Yes** _____

Glaucoma ☐ **Yes** _____

Chronic ear infections (otitis media) ☐ **Yes** _____

Hearing loss ☐ **Right** ☐ **Left** ☐ **Both**

☐ **Current Hearing Aid**

Sinus Problems (chronic sinusitis) ☐ **Yes** _____

Nasal polyps ☐ **Yes** _____

Nasal Allergies ☐ **Yes** _____

Recurrent tonsillitis ☐ **Yes** _____

Tinnitus ☐ **Yes** _____

Vertigo ☐ **Yes** _____

☐ **History of Falls**

Hematologic:

Anemia ☐ **Yes** _____

Bleeding Disorder ☐ **Yes** _____

Immunologic:

Season Allergies Type: _____ ☐ **Yes** _____

Food Allergies Type: _____ ☐ **Yes** _____

HIV/AIDS ☐ **Yes** _____

Multiple Sclerosis ☐ **Yes** _____

Integumentary

Eczema/Psoriasis ☐ **Yes** _____

Infectious Disease:

Mononucleosis ☐ **Yes** _____

Metabolic/endocrine:

Diabetes Type: _____ ☐ **Yes** _____

Thyroid deficiency (hypothyroidism) ☐ **Yes** _____

Thyroid excess (hyperthyroidism) ☐ **Yes** _____

Musculoskeletal:

Arthritis ☐ **Yes** _____

Neoplastic:

Cancer Type: _____ ☐ **Yes** _____

Neurologic:

Migraine ☐ **Yes** _____

Parkinson's ☐ **Yes** _____

Seizure Disorder ☐ **Yes** _____

Obstetric:

Currently Pregnant ☐ **Yes Due Date** _____

Psychiatric:

Depression (major) ☐ **Yes** _____

Drug Addiction ☐ **Yes** _____

Pulmonary:

Asthma ☐ **Yes** _____

COPD/Emphysema ☐ **Yes** _____

Sleep Apnea ☐ **Yes** _____

Tuberculosis ☐ **Yes** _____

Other: _____

_____

Injury **Date of accident** _____

Head ☐ **Yes** _____

Facial Fracture ☐ **Yes** _____

Injury Due to ☐ MVA ☐ Work Injury

If YES to any of the above – was surgery performed?

Where/When/By Whom?

Patient Name: _____ **DOB:** _____

FAMILY HISTORY and relationship to patient - Mother/Father/Sister/Brother/Son/Daughter

Allergies	☐ Yes
Asthma	☐ Yes
Blood Disease	☐ Yes
Cancer Type: _____	☐ Yes
Diabetes	☐ Yes
Eczema	☐ Yes
Hearing deficiency	☐ Yes
Migraines	☐ Yes
Renal Disease	☐ Yes
Seizure Disorder	☐ Yes

Other: _____

SOCIAL HISTORY:

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/Day	For? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**
_____ **# Drinks** ☐ **per day** ☐ **per week**

Caffeine Consumption?
☐ **No** ☐ **Yes** **Amount per Day?** _____
What? _____

Please complete the Review of Systems (on SEPARATE form)

What is the reason you are here today?

_____

_____

Privacy Questions (with electronic signature)
We will be asking you to sign electronic signature pad at desk to show that you have been informed of our HIPAA Privacy Policies posted in the waiting room and on our website www.ent-drs.com
A copy of these are available upon your Request

Please let us know if the following is NOT OK:

Leave appointment message on:	Leave other medical info on:
On home Phone (include Auto Call)?	On home Phone (include Auto Call)?
On Cell Phone (include Auto Call)?	On Cell Phone (include Auto Call)?
On Office Voice Mail?	On Office Voice Mail
With another person?	With another person?
Send via Mail?	Send via Mail?
Send via Email?	Send via Email?

Also please let us know at that time if there are any friends and family that you consent to share your information with if they call (we will not be permitted to speak with them unless you authorize):

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for the non-covered services. I authorize the physician to release any information required. I understand and agree that (regardless of my insurance statue) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

I acknowledge that Otolaryngology Plastic Surgery Associates, P.C. will exchange information regarding past medical and medication history for your care and treatment purposes.

Patient Signature: _____ **Date:** _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance with supplying accurate insurance information and understanding our payment policies.

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing off at 215-368-5290.

We ask that all patients read and sign our financial policy and HIPAA form as well as complete our Patient Information Form and Consent Form prior to having your examination, therapy and/or study.

All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to the insurance company on your behalf, but if the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. You will be billed for any non-covered services, co-pays, deductibles, and or co-insurance. Co-pays and/or co-insurances are due at the time of service. For your convenience, we accept Visa, Mastercard, Discover, American Express, check, cash or money order. There will be a $25.00 fee for returned checks.

We require 24-hour notice when cancelling an appointment. You will be charged a fee of 20.00 for missed appointments or appointments not cancelled within the 24-hour period.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event you do not have a referral prior to your appointment, your appointment will be rescheduled.

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 90 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection costs at the time the account is considered delinquent.

DEPENDENT CHILDREN: The parent who brings the child in for his/her visit is responsible for payment.

There will be a charge of $12.00 for form completion. Payment is due on completion of the form.

I have read and understand the above financial policy of Otolaryngology Plastic Surgery Associates, P.C. and agree to abide by this policy.

Patient or (Guardian Signature) _____ Date: _____

Patient Name _____

Patient: _____ **DOB:** _____

Thank you for electing to visit our specialists at Otolaryngology Plastic Surgery Associates. Our doctors specialize in ear, nose, and throat issues. We offer more specialized testing to better evaluate the problem you are seeking to diagnose and treat.

This form is to notify you in advance that one or more of the following procedures MAY be done at your consult appointment. Your insurance company may process these differently depending on your insurance plan. Insurance companies always consider these tests a surgical procedure, and as such, are billed in addition to your office visit (regular or post op). Your insurance may apply additional co-pay, co-insurance, and/or deductible. The below list is not an all-inclusive list, rather we are providing you with the most common ear, nose, and throat office procedures.

- 30901 Control of Nasal Hemorrhage, Simple
- 30903 Control of Nasal Hemorrhage, Complex
- 30905 Control of Nasal Hemorrhage, Posterior
- 31231 Diagnostic Nasal Endoscopy
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)
- 31238 Flexible Laryngoscopy
- 69210 or G0268 Removal of Impacted Cerumen
- 69420 Myringotomy
- 69433 Tympanoplasty
- 92557 Audiogram
- 92567 Tympanogram

You will be responsible for any additional copayment, coinsurance and/or deductible your insurance plan applies to your claim.

I certify that I have read and fully understand the above.

Patient Signature or Responsible Party: _____

Patient Name _____ **Date** _____

REVIEW OF SYSTEMS (Check any of the following problems you have recently had)

General Health Problems

☐ Fever ☐ Night sweats ☐ Unintentional weight loss

Eye problems

☐ Double vision ☐ Glaucoma ☐ Visual loss

Ear problems

☐ Ear drainage ☐ hearing loss ☐ Ear infections ☐ Dizziness ☐ Itchy ☐ Wax

☐ Noise exposure ☐ ringing/noise in ears ☐ Ear pain ☐ Tinnitus

Nose & Sinus problems

☐ Chronic congestion ☐ Nosebleeds ☐ Runny nose ☐ Postnasal drip

Mouth & Throat problems

☐ Difficulty swallowing ☐ Snoring ☐ Sore throat ☐ Hoarseness

Heart & circulation problems

☐ Chest pain ☐ Hypertension ☐ High cholesterol ☐ Heart attack

Lung or respiratory problems

☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Sleep apnea

Stomach problems

☐ Abdominal pain ☐ Diarrhea ☐ Heartburn

Brain or nervous system problems

☐ Headache ☐ Seizures ☐ Weakness ☐ Facial pain

Urinary Tract Problems

☐ Kidney stones ☐ Bladder infection

Glands & Hormone Problems

☐ Intolerance to heat or cold ☐ Diabetes ☐ Thyroid problems

Blood or Lymph nodes problems

☐ Bleeds excessively after injury ☐ Bruises easily

Allergy problems

☐ Immune deficiency ☐ HIV/Hepatitis

Skin problems

☐ Rash ☐ Latex allergies ☐ Swelling ☐ Urticaria/hives

Previous Examination

If you have had any of these tests performed in the past year, please fill out.
***Please bring results to visit if recent tests were not performed at our participating hospitals (Grand View Hospital, Doylestown Hospital) since we will not be able to access and will need all current information for a thorough visit.**

Previous ENT consults

- o Hearing test — Where and Date: _____
- o ENG or VNG — Where and Date: _____

Cardiovascular

- o EKG — Where and Date: _____
- o Stress test — Where and Date: _____
- o Holter monitor — Where and Date: _____
- o Tilt table test — Where and Date: _____
- o Cardiac echo — Where and Date: _____

Imaging

- o Head or neck CT scan — Where and Date: _____
- o Head or neck MRI — Where and Date: _____
- o Head MRA — Where and Date: _____
- o Sinus CT scan (films & results) — Where and Date: _____

Neurological

- o Carotid ultrasound/Doppler — Where and Date: _____
- o EEG — Where and Date: _____
- o Lumbar puncture — Where and Date: _____

Labs

- o CBC with differential — Where and Date _____
  - o Chemistry complete
  - o Electrolytes
  - o Fasting blood sugar
  - o Liver function

  - o Cholesterol/triglyceride or cardiac profile
  - o Thyroid function: TSH
  - o FTA-ABS and VDRL

***PLEASE PROVIDE PLACE OF SERVICE AND DATE**