



**PATIENT INFORMATION**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Please check one: Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Single \_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Referring Physician Phone #: \_\_\_\_\_

**EMERGENCY CONTACTS**

Name of relative or neighbor NOT living with you: \_\_\_\_\_ Phone: \_\_\_\_\_  
HIPPA Contacts: If you so choose - Name of relative or friend we can discuss your medical needs and account information with if necessary:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance:  
Name of person this policy is under(subscriber): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Address of Subscriber: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_  
Secondary Insurance:  
Name of person this policy is under(subscriber): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Address of Subscriber: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

**RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 YEARS OLD)/POWER OF ATTORNEY**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I hereby authorize Otolaryngology Associates, Ltd. to furnish any information required to process my insurance claim to my insurance carrier, and also authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any amount not covered by insurance.

\_\_\_\_\_  
Patient / Parent / Guardian / Responsible Party Signature

\_\_\_\_\_  
Date

**OTOLARYNGOLOGY ASSOCIATES, LTD  
MEDICAL HISTORY INFORMATION SHEET**

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Reason for visit**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Hearing Loss      | <input type="checkbox"/> Earwax         | <input type="checkbox"/> Foreign Body in Ear / Nose | <input type="checkbox"/> Mouth/Tongue Sores |
| <input type="checkbox"/> Sinusitis     | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Thyroid Nodule | <input type="checkbox"/> Vertigo/Dizziness          | <input type="checkbox"/> Second Opinion     |
| <input type="checkbox"/> Snoring       | <input type="checkbox"/> Nose Bleeds       | <input type="checkbox"/> Nasal Fracture | <input type="checkbox"/> Swallowing Difficulty      | <input type="checkbox"/> Abnormal Test      |
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Sore Throat       | <input type="checkbox"/> Neck Mass      | <input type="checkbox"/> Allergies                  |   |
| <input type="checkbox"/> Other _____   |  |   |   |   |

**How long** have you had this problem? \_\_\_\_\_

**MEDICATIONS:** List ALL medications you are currently taking. Include ALL medications even herbs and "over-the-counter" ones.

Drug Name	Dose	Frequency

List any medications you are **allergic** to: \_\_\_\_\_

**REVIEW OF SYSTEMS**

<b>General</b> <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting	<b>Skin</b> <input type="checkbox"/> Color Change <input type="checkbox"/> Rash <input type="checkbox"/> Itchy Skin <input type="checkbox"/> Skin Sore <input type="checkbox"/> Skin Lesion	<b>Head</b> <input type="checkbox"/> Headache <input type="checkbox"/> Head Injury <input type="checkbox"/> Head Lesion	<b>Eyes</b> <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Eye Redness <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Burning Eyes <input type="checkbox"/> Swelling <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Glaucoma	<b>Ears</b> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing Ears <input type="checkbox"/> Drainage <input type="checkbox"/> Earache <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Ear Infections
<b>Nose</b> <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Drainage <input type="checkbox"/> Obstruction <input type="checkbox"/> Congestion <input type="checkbox"/> Sinus Infections	<b>Mouth</b> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Sores / Ulcers <input type="checkbox"/> Tooth Problems <input type="checkbox"/> Bad Breath <input type="checkbox"/> Taste Problems	<b>Throat</b> <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hard to Swallow	<b>Neck</b> <input type="checkbox"/> Knot or Mass <input type="checkbox"/> Stiffness <input type="checkbox"/> Pain <input type="checkbox"/> Lesions	<b>Lungs</b> <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm <input type="checkbox"/> Coughed Blood <input type="checkbox"/> Short of Breath <input type="checkbox"/> Wheezing
<b>Heart</b> <input type="checkbox"/> Murmur <input type="checkbox"/> Heart Fluttering <input type="checkbox"/> Chest Pain <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clot	<b>Gastrointestinal</b> <input type="checkbox"/> Abdomen Pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<b>Neurological</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Facial Paralysis <input type="checkbox"/> Slurred Speech	<b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression	<b>Endocrine</b> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease

**MEDICAL HISTORY:** Please check those you now have or have a history of.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Migraines	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Voice Problems	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other (Specify) _____			

**PAST SURGICAL HISTORY:**

Have you had a previous surgery on your ear, nose, throat, head or neck?  Yes  No

If yes, what type of surgery? \_\_\_\_\_

List any other surgery you have had.


Have you had any recent x-rays, scans, labwork, or other type of diagnostic test?  Yes  No

If yes, what type of tests? \_\_\_\_\_

Have you ever been allergy tested?  Yes  No If yes, when? \_\_\_\_\_

Do you take allergy shots?  Yes  No

**SOCIAL HISTORY**

Do you drink alcoholic beverages?  Yes  No If yes, how much? \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, what kind and how much? \_\_\_\_\_

**FAMILY HISTORY:** Please check any of the following your father, mother, brother or sister have or had.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Problems with Anesthesia	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Cancer

\_\_\_\_\_  
Patient / Parent / Guardian / Responsible Party Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Otolaryngology Associates, Ltd.**

**Payment Policy**

It is the policy of Otolaryngology Associates, Ltd. that payment is due at the time services are provided. It is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding fees, insurance, etc.

**Self-Pay** - All self-pay patients are responsible for payment of their account at the time services are provided. For scheduled surgeries payment is due prior to the surgery date. If the entire balance cannot be paid at once, arrangements must be made in advance.

**Medicare** - The physicians of this clinic are participating providers of Medicare. Patients are responsible for their deductible and co-pay unless a Medicare supplement policy is provided.

**Medicaid** - The physicians of this clinic only accept Medicaid patients that have been seen and referred by their primary care physician. We accept Medicaid as secondary to Medicare. Under no circumstances do we accept Medicaid as secondary to any other insurance.

**Private Insurance** - The physicians of this clinic are **not** participating providers for all private insurances, and it is the **patient's responsibility** to check with business office prior to being seen if you have any questions. For insurances that we do not accept, the patient is responsible for payment in full at the time of service. For those insurances that we do accept the patient is responsible for co-pays and deductibles at the time of service. The patient is responsible for any balance remaining after the insurance has paid.

**We are participating providers for the following networks:**

<b>BCBS of Mississippi</b>	<b>BCBS of Alabama</b>
<b>AHS State Network</b>	<b>Tricare</b>
<b>MPCN (Mississippi Physicians Care Network)</b>	<b>Healthlink</b>
<b>BHSG (Baptist &amp; Physicians)</b>	

It is the patient's responsibility, not the employees of Otolaryngology Associates, Ltd., to know your plan benefits, and ultimately it is the patient's responsibility for payment. We will assist you if needed.

**I have read the above information and understand the policies of Otolaryngology Associates, Ltd. and my responsibilities as a patient.**

\_\_\_\_\_  
**Patient / Parent / Guardian / Responsible Party Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_.  
**Date**

**OTOLARYNGOLOGY ASSOCIATES, LTD. – NOTICE OF PRIVACY PRACTICES**

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

OUR PRIVACY COMMITMENT – We recognize that protecting the privacy and security of your personal and confidential healthcare information is an important responsibility. This notice will tell you how we may use and share medical information about you.

OUR LEGAL DUTY – *Law Requires Us To:*

1. Keep your medical information private.
2. Provide you with a notice of our privacy practices.
3. Follow the terms of our privacy notice and any update of this notice.

**USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

We will use and disclose elements of your protected health information (PHI) in the following ways:

1. FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may also share medical information about you with other health care providers to assist them in treating you.
2. FOR PAYMENT: We may use and disclose your medical information for payment purposes.
3. FOR HEALTH CARE OPERATIONS: Our office will use the information for business purposes such as quality improvement and to send you information.
4. When release is required by law.
5. In emergency situations or to avert serious health or safety situations.
6. To medical examiners, coroners or funeral directors to help them carry out their duties.
7. To contact you about appointments, treatment alternatives and other health related benefits and services.
8. We may share your medical information with appropriate authorities if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.
9. All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission we may have.

YOUR RIGHTS: You have the right to:

1. Request that we place additional restrictions on our use or disclosure of your medical information. (We are not required to do so.)
2. Look at or get copies of your medical information by signing a request form.
3. Receive a list of all the disclosures by us for purposes other than treatment, payment and healthcare operations.
4. Request that we communicate with you about your medical information by different means or to different locations.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed.

QUESTIONS AND COMPLAINTS – If you have and questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

I acknowledge receipt of this notice:

\_\_\_\_\_  
Signature of Patient / Patient Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date