

Welcome to our practice. The information you provide below will be used to file insurance claims, expedite your care and contact the individuals pertinent to your care. **Please complete all information.** If information does not apply, write N/A. **Please print clearly.**

### Patient Information 2017

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: S M D W Sep Race: White Black Hispanic Asian Other \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City, State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Patient is: Full Time Student \_\_\_\_\_ Employed \_\_\_\_\_ Part-Time \_\_\_\_\_ Retired \_\_\_\_\_ Self Employed \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_ Spouses D.O.B: \_\_\_\_\_

**Can we leave messages at your home? YES NO Can we leave messages at your work? YES NO**

### Responsible Party Information

(If adult, put SELF and go to next section)

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City, State Zip Code

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Shift: \_\_\_\_\_

Military Only: Active \_\_\_\_\_ Retired \_\_\_\_\_ Branch of Service \_\_\_\_\_ Rank \_\_\_\_\_

### Name/Phone number of Emergency Contact:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Patient's Family Doctor: \_\_\_\_\_ Patient's Referring Doctor \_\_\_\_\_

### Insurance Information

#### (Primary)

Ins Co Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Policyholder's D.O.B: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

#### (Secondary)

Ins Co Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Policyholder's D.O.B: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Date: \_\_\_\_\_ Chart Number: \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**WHY ARE YOU SEEING THE DOCTOR TODAY?** \_\_\_\_\_

**ADDITIONAL RELATED SYMPTOMS (please circle):**

**GENERAL:** FATIGUE, FEVER, CHILLS, NIGHT SWEATS, WEIGHT LOSS, WEIGHT GAIN

**HEAD/NECK:** HEADACHES, NECK STIFFNESS, NECK MASS (L / R / MIDLINE)

**EYES:** CHANGE IN VISION, REDNESS, DRYNESS, BURNING, ITCHY/WATERY

**EARS:** HEARING LOSS (L / R), RINGING (L / R), ITCHING (L / R), FULLNESS (L / R), DRAINAGE (L / R), PAIN (L / R), RECURRENT EAR INFECTIONS

**NOSE:** CONGESTION, RUNNY NOSE, POST NASAL DRIP, SINUS PAIN, SINUS PRESSURE, NOSE BLEEDS (L / R), LOSS OF SMELL, RECURRENT SINUSITIS, SEASONAL ALLERGIES

**MOUTH/THROAT:** ORAL ULCER / LESION / MASS, SORE TONGUE, DENTAL PAIN, DRY MOUTH, BAD BREATH, SORE THROAT, LUMP IN THROAT, TROUBLE SWALLOWING, HOARSENESS, SNORING, RECURRENT THROAT INFECTIONS

**LUNG:** SHORTNESS OF BREATH, COUGH (DRY / PRODUCTIVE / CHRONIC), WHEEZING, COUGHING BLOOD

**CARDIAC:** CHEST PAIN, IRREGULAR HEART BEAT, FAINTING

**GI:** NAUSEA, VOMITING, CRAMPING, CONSTIPATION, DIARRHEA, HEARTBURN

**SKIN:** RASH, HIVES, ITCHING, ABSCESS, LESION

**NEURO:** TINGLING / NUMBNESS, SEIZURE, DEVELOPMENTAL DELAY, DIZZINESS / VERTIGO

**MUSCLE/JOINT:** JOINT PAIN, MUSCLE CRAMPS

**ENDOCRINE:** COLD / HOT INTOLERANCE, ENLARGED LYMPH NODES

**PSYCH:** DEPRESSION, ANXIETY, DIFFICULTY SLEEPING

**HEMATOLOGY:** EASY BRUISING, FREE BLEEDING, BLOOD CLOTS

**MEDICATIONS TRIED FOR CURRENT PROBLEM (please circle):**

**ANTIHIAMINE:** ZYRTEC, ALLEGRA, XYZAL, CLARITIN, BENADRYL, CLARINEX

**LEUKOTRIENE:** SINGULAIR, ZYFLO

**INTRANASAL ANTIHIAMINE:** ASTEPRO, ASTELIN, PATANASE, OMNARIS

**NASAL SPRAYS:** NASONEX, NASACORT AQ, VERAMYST, RHINOCORT AQ, NASALCROM, AFRIN, NEOSYNEPHRINE, FLONASE

**MUCOLYTICS:** MUCINEX, NASAL SALINE SPRAY, NEILMED SINUS RINSE

**COMBOS:** ZYRTEC D, ALLEGRA D, CLARITIN D, CLARINEX D, SUDAFED, TYLENOL SINUS, TYLENOL ALLERGY

**ASTHMA:** ALBUTEROL, PROVENTIL, VENTOLIN, ADVAIR, ASMANEX, PULMICORT, SPIRIVA, SERAVENT, FLOVENT

**ANTIBIOTICS:** AMOXICILLIN, AUGMENTIN, AVELOX, BIAXIN, BACTRIM, CLINDAMYCIN, CECLOR, CEFZIL, ERYTHROMYCON, KEFLEX, LORABID, LEVAQUIN, OMNICEF, ROCEPHIN, TETRACYCLINE, VANCOMYCIN, Z-PAK

**ORAL STEROIDS:** PREDNISONE, MEDROL, ORAPRED

**REFLUX MEDS:** PRILOSEC/OMEPRAZOLE, NEXIUM, PROTONIX, ACIPHEX, KAPIDEX/DEXILANT, PREVACID, PEPCID/ZANTAC, TAGAMENT

**MIGRAINE MEDS:** RELPAX, TREXIMET, IMITREX, TOPAMAX, ZATIDOR

**EYE DROPS:** NASAREL, OPTIVAR, PATADAY, CROMOLYN

**EAR DROPS:** ACETASOL, AURALGAN, CIPRODEX, CIPRO HC, DERMOTIC OIL, DEBROX, TIROXIN, OFLOXACIN, CLOTRIMAZOLE

**OTHER:** \_\_\_\_\_

**PAST PERSONAL MEDICAL HISTORY (please circle):**

ACID REFLUX, ASTHMA, CANCER: \_\_\_\_\_, COPD, DIABETES, HEART MURMUR, HEART ATTACK, HEART FAILURE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, HIV, KIDNEY FAILURE, LIVER DISEASE, SLEEP APNEA, STOMACH ULCER, STROKE, THYROID DISORDER (HYPO / HYPER / NODULES), OTHER \_\_\_\_\_

**PAST SURGICAL HISTORY (please list):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Patient Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

**Hampton Roads Otolaryngology, PLLC (herein referred to as HROA) appreciates the confidence you have shown in choosing us to provide for your healthcare needs. Below are our general policies. Please review this information and sign where indicated.**

**Patient Financial Policies**

I understand that it is my responsibility to provide HROA with current, accurate billing information at the time of check in and to notify HROA of any changes in this information.  
I understand that it is my responsibility to pay my co-pay at the time services are rendered. I understand that this is a contractual agreement that I have with my health plan and that HROA also has a contract agreement with my health plan to collect co-pays at the time of service.  
I understand that I will be billed for any amounts due by me including co-insurance amounts, co-payments and deductibles and that I have a financial responsibility to pay these amounts.  
I understand that insurance claims pending which exceed the agreed upon time limit for payment with respect to the term of my insurance company's contract with my provider are my responsibility.  
I understand that if any charges billed to me are still outstanding after 90 days from the date services were rendered, my account may be referred to a collection agency or an attorney for collection, unless other acceptable payment arrangements can be made. I agree to pay all costs of collection, including but not limited to, **thirty five percent collection** agency fees plus attorney fees and court costs. In the event my account is in default, I agree to pay interest at the rate of (18%) per annum from and after the date of treatment. I hereby waive the benefit of my homestead exemption as to this debt.  
I understand it is my responsibility to obtain a referral (if required by your insurance company). If this referral is not obtained, then all charges will be the responsibility of the guarantor.  
I understand there is a \$50.00 fee for any check returned from my bank.  
I understand that if I do not cancel an appointment 24 hours prior to my scheduled appointment time, or if I do not show for my appointment, there may be a \$25.00 fee. If I cancel/no show three appointments, I may be released from care. If I am released, I will be notified in writing by HROA.  
I have read the above policy regarding my financial responsibility to HROA for providing services to me or the above named patient. I authorize my insurer to pay any benefits directly to HROA, the full and entire amount of the bill incurred by me or the above named patient.

\_\_\_\_\_  
Patient/Legal Guardian Name (Print)      Patient/Legal Guardian Signature      Date

**Consent for Treatment & Authorization for Release of Information**

I hereby authorize HROA through its appropriate personnel, to perform or have performed upon me, or the above named patient appropriate assessment & treatment procedures. Upon assessment by the physician, an endoscope may be used in order to further evaluate the nasal or sinus cavity, which may result in an additional charge determined by your insurance plan.  
I understand that in the course of treatment, there is a possibility that HROA healthcare workers may become exposed to my blood or body fluids. State laws require a sample of my blood be tested for the presence of infectious diseases. The results of the tests will be released to me and the healthcare worker that was exposed. I further authorize HROA to release any & all medical information on myself or the above named patient to my insurance company to process my claim and hereby authorize a copy of my medical information be sent to my primary care physician as well as any attending or consulting practitioners.

\_\_\_\_\_  
Signature/Relationship to Patient      Signature/Relationship to Patient (print)      Date

**Acknowledgement of Review of Notice of Privacy Practices  
And Marketing Option Selection**

**Patient Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

I have reviewed the Notice of Privacy Practices for this practice and received a copy for my records, if requested. I consent to release of my Protected Health Information for the purposes of treatment, payment, and healthcare operations (as defined in the Notice). I understand that any release of information beyond these three purposes or any other legally permitted release requires a separate authorization.

\_\_\_\_\_  
**Patient/Parent/Guardian Name (print)      Patient/Parent/Guardian Signature      Date**

We must allow you the opportunity to opt-out of receiving information from our practice regarding treatment options available to you and other services we offer now and in the future. We will never release your information to a third party outside the scope of our Privacy Practices as explained on the Notice. If you do not make a selection and sign below, we will assume that you have consented to receive this information from us. Please make a selection below:

- Yes, I would like to receive information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.
- No, I do not want information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.

\_\_\_\_\_  
**Patient/Parent/Guardian Name (Print)      Patient/Parent Guardian Signature      Date**

**Authorization for Release of Medical Information**

I, \_\_\_\_\_, (patient's name) hereby authorize Hampton Roads Otolaryngology Associates, PLLC to release or discuss any of my medical information with the follow individuals: (We cannot discuss any medical information with other physicians unless noted on your patient information form or listed here) Please include any friends and family members you may authorize to have access to any of your information

<b>Name</b>	<b>Relationship to Patient</b>
_____	_____
_____	_____
_____	_____
_____	_____

**If you would like to set limitations on what medical information can be released to these individuals please list below what information we may provide. If you would like no limitations set then just write ALL.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Please note that this authorization will expire in 1 year. If you would like to set a particular expiration date for less than 1 year please specify:** \_\_\_\_\_

\_\_\_\_\_  
**Patient/Legal Guardian Signature      Relationship to Patient      Date**