MRN:_____

ENT Specialists of Huntsville

Patient Name: _____ **DOB:** _____ **TODAY's DATE:** _____

Phone#_____

RACE _____ PRIMARY LANGUAGE _____ HISPANIC / NOT HISPANIC

HOME ADDRESS _____

APTS STREET #

_____

CITY STATE ZIP

DRIVERS LICENSE # _____ ISSUING STATE _____

RESPONSIBLE PARTY - Person must sign paperwork & be present the day of appointment

_____

PATIENT {OR RESPONSIBLE PARTY) EMPLOYED BY: _____

OCCUPATION _____

PATIENT SSN _____ (OPTIONAL, UNLESS NEEDED FOR INSURANCE]

NAME OF PRIMARY INSURANCE COMPANY _____

MEMBER/CONTRACT/ID # _____GROUP # _____

SUBSCRIBER'S NAME / DOB _____/ _____EMPLOYER _____

RELATIONSHIP TO PATIENT _____

NAME OF SECONDARY INSURANCE COMPANY _____

MEMBER/CONTRACT/ID # _____GROUP # _____

SUBSCRIBER'S DOB _____EMPLOYER _____

RELATIONSHIP TO PATIENT _____

** EMERGENCY CONTACT: NAME AND PHONE NUMBERS —PLEASE ALSO LIST PERSON on Authorized to receive information form

_____

STATEMENT OF RESPONSIBILITY

I ACCEPT RESPONSIBILITY PAYMENT FOR ALL SERVICES REGARDLESS OF INSURANCE COVERAGE. SHOULD ANY PART OF THIS BILL BECOME DELINQUENT›, I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 50% OF THE DEBT AND ALL COST AND EXPENSES INCLUDING REASONABLE ATTORNEY'S FEES INCLUDED

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: **X**_____

MRN:_____

ENT Specialists of Huntsville

Referring or Primary Doctor / Nurse Practitioner: _____ City/State: _____

REASON FOR APPOINTMENT TODAY: _____
DURATION OF PROBLEM: _____

HEALTH HISTORY: HEIGHT: _____. WEIGHT: _____

PLEASE LIST CURRENT OR PAST MEDICAL PROBLEMS:

Bleeding / Blood Disorder	Heart Disease	Liver disease	Other:
Cancer: Type: _____	High Blood Pressure	Lung Disease	_____ _____
Diabetes	Kidney Disease	Thyroid Disorder	_____

PHARMACY INFORMATION: _____Phone: _____

MEDICATIONS: NONE

Please list ALL regularly taken medications including over the counter non-prescription:

Name	Dosage	Frequency

ALLERGIES TO MEDICATIONS

NONE Penicillin(s)

Sulfa Drugs Latex

Other Allergies:

_____
_____
_____
_____

SURGERIES: DATE:

SOCIAL HISTORY

Are you currently pregnant? Yes / No If yes, _____weeks

Have you ever smoked? Yes / No If yes, pack per day for months/yrs

When did you quit? _____

Are you exposed to second-hand smoke? Yes / No

Do you drink alcohol? Yes / No Occasionally Socially Regularly

Do you wear dentures / partials? Yes / No Upper Lower Both

Do you wear hearing aids? Yes / No

FAMILY HISTORY OF MAJOR MEDICAL ISSUES (PARENTS / SIBLINGS) (Please Circle):

Cancer Diabetes Stroke High Blood Pressure Bleeding Disorders Heart Disease _____

MRN:_____

ENT Specialists of Huntsville

Review of Systems:

Circle any illnesses, problems, or symptoms which apply to you:

CONSTITUTIONAL SYMPTOMS

Good general health lately

Recent weight change, Loss of appetite, Excessive Tiredness

EYES

Eye disease or injury
Blurred or double vision
Glaucoma

EARS / NOSE / MOUTH / THROAT

Hearing loss
Ringing in the ears (Tinnitus)
Earaches or drainage
Nosebleeds
Trouble swallowing
Bleeding gums
Sore throat
Snoring
Voice changes Nasal congestion
Nasal discharge (clear / yellow / green)

MUSCULOSKELETAL

Joint pain / Stiffness
Muscle pain / Cramps / Weakness
Back pain

CARDIOVASCULAR

Chest Pain or Angina
Palpitations
Shortness of breath walking or lying flat
Swelling of feet, ankles or hands
Murmur

RESPIRATORY

Cough
Spitting up blood
Shortness of breath
Wheezing

GASTROINTESTINAL

Problems with bowel movements
Nausea or vomiting
Rectal bleeding or blood in stool
Abdominal pain or heartburn

GENITOURINARY

Flank pain
Difficulty with urination
Kidney stone

NEUROLOGICAL

Headaches
Numbness or tingling sensations
Tremors
Head injury
Dizziness

PSYCHIATRIC

Memory loss or confusion
Nervousness
Depression
Insomnia

HEMATOLOGIC / LYMPHATIC

Bleeding or bruising tendency
Phlebitis / Blood clots
Past transfusion

MRN:_____

ENT Specialists of Huntsville

To facilitate communication, we would like to have email and text messaging available regarding scheduling and reminders as an option for our patients. Understandably, there is no way to ensure that the messages would remain confidential to you. At no time will this information be shared by us with other parties. No scheduling will be performed without a response of confirmation from you, the patient, or a guardian.

***Any Emergencies / Urgent medical matters must still be addressed by telephone. to ensure reliable and timely communication. ***

You may text us anytime, however, ***Text messages are monitored only during normal business hours.***

Please note your preference and permission of contact and reminders and provide the information below:

Text messaging #: _____

Cell phone carrier: _____ (to facilitate means of texting)

Email address: _____

Best daytime phone #: Same as above or:_____

Best evening phone #: Same as above or: _____

ENT Specialists of Huntsville

MRN:_____

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by **ENT SPECIALISTS OF HUNTSVILLE** or disclosed to others for the purposes of treatments, obtaining payment, or supporting the day-to-day health care *operations* of the practice.

THE NOTICE OF PRIVACY PRACTICES

ENT SPECIALISTS OF HUNTSVILLE is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this Information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. PLEASE **REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION:

You may request a restriction on the use or disclosure of your protected health information. However, **ENT Specialists of Huntsville** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if **ENT Specialists of Huntsville** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy brochure, please consult with a practice representative at this location and contact information listed on the back of the brochure

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, **ENT Specialists Huntsville** requires that you must revoke this this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

ENT Specialists of Huntsville reserves the right to change or modify the privacy practices outlined in the Notice of Privacy brochure. **ENT SPECIALISTS OF HUNTSVILLE** will notify you of any changes of privacy practices either by mail or at your next appointment, or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **ENT SPECIALISTS OF HUNTSVILLE** to use and disclose my health information in accordance with this consent and the notice provided.

_____

Name of Patient (Please Print)

_____

Signature of Patient / Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

ENT Specialists of Huntsville

MRN:_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ENT Specialist of Huntsville, P.C. to release to my insurer's full information, including copies of records and operative notes relative to my illness.

SIGNATURE OF PATIENT OR GUARDIAN: _____

DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS

Insurance will only be filed for surgery or office procedures unless your insurance plan is one in which **ENT Specialists of Huntsville** is a participating provided: Insurance will be filed for all services rendered to patients insured by such plans. The assignment of benefits only applies to insurance filed by this office.

I hereby authorize payment to be made directly to Mark L Hagood, M.D. LLC, dba ENT Specialists of Huntsville provider of services filed for**. I understand that I am financially responsible for charges not covered by this assignment of benefits**.

SIGNATURE OF PATIENT OR GUARDIAN: _____

DATE: _____

A copy of this signature shall be as valid as the original

MRN:_____

ENT Specialists of Huntsville

Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

The health information this practice collects on you may be disclosed to the following persons:

_____ _____

Name of Person / Relationship to Patient

Name of Person / Relationship to Patient

_____ _____

Name of Person / Relationship to Patient

Name of Person / Relationship to Patient

Use and Disclosure of Information:

____ I authorise the person(s) listed above to recieve all health information about appointments, treatments, and or other information pertinent to my health care and/or payment for services by ENT Specialists of Huntsville.

____ I DO NOT authorize the following information to be disclosed to any other parties except to me as the patient Please specify:

Expiration Date of Authorization

This authorization will expire upon the minor's age of majority (19 *years old*) or upon termination or update by the patient or the patient's personal representative or guardian.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to ENT Specialists of Huntsville's authorized representative.

Potential for Re-disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

SIGNATURE

Name of patient: _____

_____

Signature of Patient / Date

_____

Signature of patient representative

_____

Relationship of representative to patient