WELCOME TO OUR OFFICE

EASTERN SHORE ENT CLINIC, P.C.

251-928-0300

Thank you for choosing our office. In order to serve you properly, we will need the following information. ***Please print.*** *All information will be strictly confidential.*

Legal Name: _____ Sex: M F Date of Birth: _____
(Patient) (Last) (First) (Middle) (circle one)

Mailing Address: _____
(Street) (Apt. #) (City) (State) (Zip Code)

Address (If different) _____
(Street) (Apt. #) (City) (State) (Zip Code)

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Social Security Number: _____ Circle One: Child Single Married Divorced Widow

Race: (Circle one) White American Indian or Alaskan Native Black or African American Asian
Native Hawaiian or Other Pacific Islander Some Other Race Decline to State

Ethnicity (Circle one) Caucasian Hispanic or Latino Not Hispanic or Latino Decline to State

Name of Patient's Employer: _____ Address: _____ Phone: _____

Name of Spouse: _____ Date of Birth: _____

Spouse's Social Security Number: _____ Spouse's Cell Phone: _____

Name of Spouse's Employer: _____ Phone: _____

In the event of an emergency, who should we contact? _____

Address _____
(Street) (City) (State) (Phone)

COMPLETE SECTION BELOW IF YOU ARE PARENT/GUARDIAN OF A MINOR PATIENT

Legal Name: _____ Sex: M F Date of Birth: _____
(Last) (First) (Middle) (Circle one)

Mailing Address (If different) _____
(Street) (Apt. #) (City) (State) (Zip Code)

Home Phone: (____)_____ Work Phone: (____)_____ Relationship to Patient: _____

Social Security Number: _____ Employer of Responsible Party: _____

Name of spouse: _____ Date of Birth: _____

Spouse' Social Security Number: _____ Phone: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

_____ _____
Signature of parent requesting care Date

EASTERN SHORE EAR, NOSE & THROAT CLINIC, PC

NAME:_____DOB:_____PRIMARY M.D._____

Which physician sent you to our office for this consultation?_____

Have other members of your family by seen in this office? If so, name: _____

REASON FOR VISIT:_____

REVIEW OF SYSTEMS

Indicate below any symptoms **YOU ARE CURRENTLY HAVING:**

Please mark the NO column if you do not have these symptoms.

	Yes	No
1. Constitutional:		
A. Weight Loss	___	___
B. Fever	___	___
C. Fatigue	___	___
2. Ear, Nose, Throat:		
A. Ringing in Ear	___	___
B. Hearing Loss	___	___
C. Sinusitis	___	___
D. Hoarseness	___	___
E. Nosebleeds	___	___
3. Opthalmological:		
A. Loss of vision	___	___
B. Blurred vision	___	___
C. Double vision	___	___
4. Respiratory		
A. Cough	___	___
B. Shortness of breath	___	___
C. Coughing blood	___	___
5. Cardiovascular		
A. Chest pain	___	___
B. Irregular heartbeat	___	___
C. Light headedness	___	___
6. GI:		
A. Difficulty swallowing	___	___
B. Diarrhea	___	___
C. Nausea	___	___
7. Allergy:		
A. Hay fever	___	___
B. Wheezing	___	___
C. Swelling	___	___

	Yes	No
8. GU:		
A. UTI's	___	___
B. Difficulty urinating	___	___
9. Neurological		
A. Dizzy	___	___
B. Headache	___	___
C. Seizure	___	___
10. Musculoskeletal		
A. Muscle pain	___	___
B. Muscle weakness	___	___
11. Heme/Lymph:		
A. Easy bruising	___	___
B. Blood clots	___	___
C. Swelling(lymph node)	___	___
12. Endocrine		
A. Hot/cold intolerance	___	___
B. Night sweats	___	___
13. Skin		
A. Rash	___	___
B. Itching	___	___
C. Sores	___	___
14. Psych:		
A. Depression	___	___
B. Anxiety	___	___
C. Insomnia	___	___

PHARMACY: _____**LOCATION:** _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp. _____

PAST SURGICAL HISTORY:

Have you had any problem with general anesthesia in the past? ___Yes ___No

List **ALL** previous surgeries with approximate dates: _____

_____

_____

_____

NAME:_____

INDICATE BELOW ANY HISTORY OF DISEASES YOU HAVE HAD:

	YES	NO		YES	NO
Arthritis	___	___	Hepatitis	___	___
Asthma	___	___	High Blood Pressure	___	___
Bleeding Tendency	___	___	High Cholesterol	___	___
Cancer: type: _____	___	___	Lung Disease	___	___
Diabetes	___	___	Reflux (Heartburn)	___	___
Glaucoma	___	___	Sleep Apnea	___	___
HIV/AIDS	___	___	Thyroid Disease	___	___
Heart Disease	___	___	Urinary Disease	___	___

List any other health conditions:

_____

_____

SOCIAL HISTORY:

Current or previous occupation: _____

	Yes	No	
Are you pregnant?	___	___	
Alcohol Use?	___	___	Amount _____ per week
Recreational Drug Use:	___	___	
Tobacco Use?	___	___	Year Quit _____ If smoking, ___ packs per day for _____ years

FAMILY HISTORY

Indicate below the diseases in **YOUR PARENTS, BROTHERS OR SISTERS:**

	Yes	No		Yes	No
Cancer: type:_____	___	___	Hearing Loss	___	___
Heart Disease	___	___	Diabetes	___	___
High Blood Pressure	___	___	Bleeding Abnormalities	___	___
Lung Disease	___	___	Allergies	___	___

List any other health conditions:_____

_____

ALLERGIES TO MEDICATION: If none, check here: ___

Name:	Reaction	Name	Reaction

CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION (include over-the-counter medications and any vitamins and herbal supplement):

NAME OF MEDICINE	DOSE/STRENGTH	HOW OFTEN
Example: Tylenol	325 mg	every 4-6 hours as needed

PATIENT AUTHORIZATION LIST

The following person(s) have permission to receive medical and/or non-medical information relative to my treatment by EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C. This includes discussion with clinical personnel with regard to treatment provided me by physicians of EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C., and test results ordered by physicians of EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C., and/or discussion with clinic personnel with regard to any financial matters relating to treatment received from EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C.

NAME	RELATION	MEDICAL, NON-MEDICAL BOTH

Signature - Patient or Legal Guardian

Date

Name of Patient

Chart Number

FINANCIAL POLICY

OUR PRACTICE FINANCIAL POLICY

We are committed to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, American Express and Discover.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, as a courtesy. In this case, your insurer may send the payment directly to you. Therefore charges for your care and treatment are due at the time of the service.

We will also bill your health plan for all services we provide in the hospital. Separate financial policies are in effect regarding any elective outpatient services provided by our clinic.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Children, 14 years of age or younger, who are not accompanied by a parent or legal guardian, must have written authorization for treatment signed by a parent or guardian, who will also be responsible for payment at the time of service.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, it is our policy that you notify at least 24 hours should you need to cancel your appointment. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of Eastern Shore Ear, Nose and Throat Clinic, P.C. and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by Eastern Shore Ear, Nose and Throat Clinic. P.C.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-Responsible Party

_____

Please Print the Name of the Patient

EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C.

EFFECTIVE DATE APRIL 1, 2003

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact **Karen Robbins, Privacy Officer at (251) 928-0300.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**