ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation/Titular: Mr.___ Mrs.___ Ms.___Miss___ Dr.___

Patient Name/Nombre del Paciente: _____

Date of Birth/Fecha de Nacimiento:_____ Age/Edad:_____

Sex/Sexo: F___ M ___ Marital Status/Estado Civil: M ___ S___ D ___ W___ Other___

Please check appropriate response:

* *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____

Native Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street City, State Zip

Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you?_____

Referring Physician:_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ ____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____Date:_____

GULF COAST FACIAL PLASTICS
& ENT CENTER
ENT and Allergy Associates
of Florida

(Print Patient Name)

D.O.B: _____

Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response:** ☐ **Yes** ☐ **No**

(Print Patient Name)

D.O.B: _____

Patient Initials

PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

ENT and Allergy Associates of Florida, P.A. uses a third party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/ Guardian Signature:_____ **Date:**_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/ Guardian Signature:_____ **Date:**_____

ENT and Allergy Associates of Florida

Caring For Our Patients Since 1963

www.entaaf.com

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ M or F

Referring Physician: _____

*Pharmacy Name _____

*Pharmacy Cross Street _____

*Pharmacy Phone Number _____

Primary Care Physician: _____ **Weight:** _____ **Height:** _____

Briefly, why are you seeing our physician today? _____

1. Patient History - Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	( )	( )	Nasal: Allergies	( )	( )
Heart (enter details below)	( )	( )	Nasal: Nasal Trauma	( )	( )
Cardio: Hypertension	( )	( )	Nasal: Nose Bleeds	( )	( )
Ear: Dizziness	( )	( )	Nasal: Sinusitis	( )	( )
Ear: Hearing Loss	( )	( )	Neuro: Headaches/Migranes	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )	Neuro: Nervous System	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	Oral: Sleep Apnea	( )	( )
G.I.: Liver Disorders	( )	( )	Pysch:Psychiatric Disorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )	Pulm: Lungs	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )	Pulm: Tuberculosis	( )	( )
Immuno: HIV	( )	( )	Uro:Bladder Disorders	( )	( )
Immuno: Immune Dieases	( )	( )	Uro: Kidney	( )	( )
Lymph: Anemia	( )	( )			
Lymph: Bleeding Disorders	( )	( )	Other: _____		

Details of Yes answers: _____

_____

2. Surgeries - Please list any surgeries/hospitalizations: _____

_____

3. Social History - Are you a current smoker? (Y or N) You now smoke _____packs of cigarettes a day.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

How many caffinated beverages do you drink per day? _____

4. Family History - Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers: _____

Patient Signature: _____ Date: _____

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of Florida
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Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ No Known Drug Allergies

MEDICATIONS: Date: _____ **Reconciled by:**_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

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Patient/Guardian Signature: _____

Print Patient Name: _____ **D.O.B:**_____