Chart #: _____ **Date:** _____

Gulf Coast Facial Plastics & ENT Center

Patient Information

(Both front and back must be filled out completely in order to be treated)

PATIENT INFORMATION					
Patient Name:			**Date of Birth:**	**SSN:**	
Marital Status: S M W D	**Sex:** M F	**Race:**	**Ethnicity:**	**Preferred Language:**	
Mailing Address:		**City:**		**State:**	**Zip:**
Home Phone #:	**Cell Phone #:**		**E-Mail:**		
Place of Employment:		**Work Phone #:**		**May we contact you at work to schedule surgery? Y N**	
Responsible Party (if a minor):		**Relationship to Patient:**		**Responsible Party's SSN:**	
Emergency Contact:		**Relationship to Patient:**		**Emergency Contact Phone #:**	

How did you hear about us? Please be specific with your selection. (If more than one, please check all that apply.)

Doctor _____ **Social Media** _____ **Newspaper** _____ **Radio** _____ **Ins. Website** _____ **Other** _____

Friend _____ **Yellow Pages** _____ **Television** _____ **Google** _____ **Internet** _____

Insurance Information

(Please Provide Insurance Card and Picture ID)

Primary Insurance Co Name:	**Policy #:**	**Group #:**
Insured's Name:	**Insured's Date of Birth:**	**Insured's SSN:**
Insured's Relationship to Patient:	**Is this visit from the result of an accident? Y N** **If yes, date of accident:**	
Secondary Insurance Co Name:	**Policy #:**	**Group #:**
Insured's Name:	**Insured's Date of Birth:**	**Insured's SSN:**
Insured's Relationship to Patient:	**Have you enrolled in the Obamacare Plan?** ☐ Yes Effective Date:_____ ☐ No	

Chart #: _____ **Date:** _____

My Financial Responsibility for Office Visits and Office Services

If you have…	You are responsible for…	Our staff will…
Commercial Insurance	Payment of the patient responsibility for all office visits and other procedures/charges are due at the time of your office visit.	File an insurance claim on your behalf.
HMO & PPO Plans with which we are contracted	If the services you receive are covered by your plan: All applicable co-pays and deductibles are requested at the time of your office visit. If the services you receive are NOT covered by the plan, payment in full is requested at the time of your visit.	File an insurance claim on your behalf.
HMO and PPO Plans with which we are NOT contracted	Payment in full for office visits and other procedures/charges are due at the time of your office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Medicare	If you have not met your $147.00 deductible, we ask that it be paid in full at the time of service. Any services not covered by Medicare are requested in full at the time of your visit. If you have a secondary insurance policy, no payment is necessary at the time of your visit. If you have no secondary insurance, payment of your 20% coinsurance is requested at the time of your visit.	File an insurance claim on your behalf, as well claims to your secondary insurance, if applicable.
No Insurance	There is a $100.00 fee for all office visits; plus, additional fee's for any procedure's performed. Payment for services is due in full at the time of your visit.	We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

For All Insurances - Please note: If you are scheduled for surgery or an in-office procedure, our office will clear the procedure through your insurance company to determine the co-pays, deductibles and non-covered procedures.

Our office is contracted with the following insurance carriers (not an exclusive list):

Aetna
Blue Cross and Blue Shield
Cigna
Humana
Medicaid
Medicare
Tricare
UnitedHealth Care

Chart #: _____ **Date:** _____

Health History Inventory
Gulf Coast Facial Plastics & ENT Center
Dr. Daniel C. Daube Dr. James C. Beggs Dr. Stephen J. Toner
Dr. Vicki Nowak Dr. Brian Gibson

Patient Name: _____

What is your reason for today's visit? _____

What is your occupation? _____

Who is your personal physician at this time? _____

What Pharmacy do you prefer? _____

Do you smoke?
- ☐ Yes, I have smoked ____ packs of cigarettes a day for ____ years.
- ☐ Yes, I smoke cigars or a pipe.
- ☐ No, I quit ____ years ago. At that time, I was smoking ____ packs a day for____ years.
- ☐ No, I have never smoked.

What is your alcohol consumption?
- ☐ Never or rarely
- ☐ No, but I used to drink
- ☐ Daily
- ☐ 1 or more times a week
- ☐ 1 or more times a month

Do you have inside dogs/cats? ☐ Yes ☐ No

If under the age of 18 years:
- Does your child attend school/daycare? ☐ Yes ☐ No
- Is your child up to date on vaccinations? ☐ Yes ☐ No

Please list any surgeries or hospitalizations:

Surgery/Hospitalization	Year	Complications

Please list your current medications:

Current Medication(s)	Dose	Frequency

Please list any other over-the-counter medications, herbal supplements or vitamins, which you take on a daily basis:

Current Medication(s)	Dose	Frequency

Chart #: _____ **Date: _____**

CHECK ALL THAT APPLY TO YOU:

☐ Stroke	☐ Seizure	☐ Thyroid Disease	☐ Asthma/ Bronchitis
☐ Cancer	☐ High Blood Pressure	☐ Hyperthyroidism	☐ Hepatitis
☐ Anemia	☐ Bleeding Disorder	☐ Hypothyroidism	☐ AIDS/HIV
☐ Hiatal Hernia/ Acid Reflux	☐ Diabetes	☐ Goiter	
☐ Kidney Disease	☐ Arthritis	☐ Heart Disease	

If Cancer Circled, specify type: _____

***Other Illnesses: _____**

Family History: Check all that apply (We are mandated by the Federal Government to Collect this Information)

	Mother	Father
Date of Birth		
Date of Death		
Alzheimer's		
Arthritis		
Cancer		
Cardiac Disease		
COPD		
Dementia		
Diabetes		
High Blood Pressure		
Kidney Disease		
Stroke		
Thyroid Problems		

Do you have any allergies to any medications? ☐ Yes ☐ No **If Yes, please explain**_____
_____
_____

Do you have any known allergies? ☐ Yes ☐ No **If Yes, please explain** _____

Are there any other medical problems that are not related to this visit that you would like us to arrange? ☐ Yes ☐ No **If Yes, please explain:** _____
_____
_____

_____
Patient or Guardian Signature
I certify the above is accurate.

_____
Physician Signature
I certify I reviewed with the patient