ADULT

EAR, NOSE & THROAT SPECIALIST OF TULSA, L. L. P.

TODAYS DATE: _____ REASON FOR VISIT: _____

DEMOGRAPHICS

LAST NAME : _____ ADDRESS: _____

FIRST NAME: _____ _____

MIDDLE NAME: _____ _____

SOCIAL SECURITY # _____ PREFER TO BE CALLED: _____

DATE OF BIRTH: _____ AGE: _____ HOME PHONE: _____ CELL PHONE: _____

MARITAL STATUS: _____ SEX: _____ E-MAIL: _____ FAX: _____

EMPLOYER: _____ WORK #: _____ JOB TITLE: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

RESPONSIBLE PARTY (If other than patient)

LAST NAME : _____ ADDRESS: _____

FIRST NAME: _____ RELATIONSHIP TO PATIENT: _____

MIDDLE NAME: _____ HOME PHONE: _____ WORK #: _____

EMPLOYER: _____ CELL PHONE: _____ PAGER #: _____

PRIMARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____ INSURED'S RELATIONSHIP TO PATIENT: _____

INSURANCE CO: _____ POLICY OR ID NO: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SOCIAL SECURITY NO: _____

GROUP NO: _____ PLAN TYPE: _____ AUTHORIZATION REQUIRED? _____

POLICY EFFECTIVE DATE: _____ EMPLOYER: _____

SECONDARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____ INSURED'S RELATIONSHIP TO PATIENT: _____

INSURANCE CO: _____ POLICY OR ID NO: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SOCIAL SECURITY NO: _____

GROUP NO: _____ PLAN TYPE: _____ AUTHORIZATION REQUIRED? _____

POLICY EFFECTIVE DATE: _____ EMPLOYER: _____

SIGNATURE: _____ DATE: _____

EAR, NOSE & THROAT SPECIALIST OF TULSA, L.L.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT
Ear, Nose and Throat Specialist of Tulsa, L.L.P. and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION
Patient medical records and billing information are created and retained by Ear, Nose and Throat Specialist of Tulsa, L.L.P. and are accessible to its personnel and medical staff for use in my care. Ear, Nose and Throat Specialist of Tulsa, L.L.P. personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Ear, Nose and Throat Specialist of Tulsa, L.L.P. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Ear, Nose and Throat Specialist of Tulsa, L.L.P., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS
You agree that insurance benefits for Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges payable to the insured are to be made payable to Ear, Nose and Throat Specialist of Tulsa, L.L.P. and that insurance benefits for services provided by physicians in the hospital setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY
You understand that Ear, Nose and Throat Specialist of Tulsa, L.L.P. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or hospital, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY
As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Ear, Nose and Throat Specialist of Tulsa, L.L.P. Charges for services and goods shall be at Ear, Nose and Throat Specialist of Tulsa, L.L.P.'s billed charges rates unless otherwise agreed to in writing by Ear, Nose and Throat Specialist of Tulsa, L.L.P.

PATIENT'S CERTIFICATION
I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____
Signature of Patient or Patient's Legally Authorized Representative (*Documentation Must Be Provided*)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Ear, Nose and Throat Specialist of Tulsa, L.L.P. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgement. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of Ear, Nose and Throat Specialist of Tulsa, L.L.P. Notice of Privacy Practices dated_____

_____	_____	_____
Patient or Representative	Legal Authority of Representative	Date Signed

Basis for refusal, if refused: _____

Confidential Communication Request

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I,_____(print your name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Telephone Contact Information:

Home #:_____ ❑Do ❑Do not leave messages on my voice mail

Work #:_____ ❑Do ❑Do not leave messages with any other person

Cell #:_____ ❑Do ❑Do not leave messages with any other person

Please list other persons that may be contacted with confidential communications

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Signed:_____ Date:_____

Print Name:_____

If not signed by the patient, please indicate:
Relationship:
- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient
- ❑ other (specify)_____

For office use only:

Date Granted:_____ Initials:_____

Adult Form

Ear, Nose and Throat Specialists of Tulsa

Initial History Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

_____

SOCIAL HABITS:

Yes___ No___ Do you regularly smoke? Cigarettes___ Pipe___ Cigars ___
For how many years?_____ How many per day? _____

Yes___ No___ Do you regularly drink over 6 cups of coffee per day?

Yes___ No___ Do you regularly drink alcohol?
BEER:_____ amount/per day WINE:_____ amount/per day

Yes___ No___ Do you have difficulty in falling asleep?
If yes, how often? _____

Yes___ No___ Do you exercise regularly?

Health History:

Cancer	Yes / No	Loss of Consciousness	Yes / No
Diabetes	Yes / No	Bleeding Tendency	Yes / No
Heart Disease		*Digestive Diseases*	
-Heart Attack	Yes /No	-Colitis	Yes / No
-Rheumatic Fever	Yes / No	-Stomach Ulcers	Yes / No
-Congenital	Yes / No	-Hiatal Hernia/Reflux	Yes / No
-High Blood Pressure	Yes / No	Liver Disease	Yes / No
-Palpitations/Flutter	Yes / No	*Genital/Urinary*	
-Pacemaker	Yes / No	-Kidney Disease	Yes / No
Respiratory Disease		-Difficulty Voiding	Yes / No
-Chronic Cough	Yes / No	Serious Illness	Yes / No
-Hay Fever	Yes / No	Serious Injury(ies)	Yes / No
-Shortness of Breath	Yes / No	Goiter/Thyroid Disease	Yes / No
-Asthma	Yes / No	Migraine/Headache	Yes / No
-Positive TB Test	Yes / No	Depression	Yes / No
Seizure/Strokes	Yes / No	Nervous Breakdown	Yes / No

Allergies:

		List Drug Allergies
Latex Rubber:	Yes/ No /Unknown	_____
Shellfish:	Yes/ No /Unknown	_____
X-ray Dye:	Yes/ No /Unknown	_____

Family History:

	AGE	Any Illnesses
Father _____	_____	_____
Mother _____	_____	_____
Brother/Sisters (circle sex)		
_____	M F	_____
_____	M F	_____
_____	M F	_____
Sons/Daughters(circle sex)		
_____	M F	_____
_____	M F	_____
_____	M F	_____

Medications:

Including asprin, laxatives, birth control pills, cough mediacation and ALL prescriptions.

Name:	Dose:	Frequency	Last Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

_____

_____

_____

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_____