Date: _____/_____/_____

ENT
Ear, Nose & Throat
Associates of Tuscaloosa, P.C.

Account: _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Date of Birth: ____/____/____ Age: _____ Sex: M ____ F ____ Email: _____

Spouse: _____ Home Phone: (____) _____

Cell Phone: (____) _____ ____ Emergency Phone: (____) _____

Ok to text appointment reminders? ___ Yes ____ No Cell Carrier: _____ (Ex: At&t, Verizon)

Employer: _____ Work Phone: (____) _____

Nearest Relative Not Living with Patient: _____ Phone: (____) _____

Race: ___ White/Caucasian
___ Black/African American
___ Hispanic
___ Filipino
___ Japanese
___ Chinese
___ Asian
___ Native American
___ Native Hawaiian

Preferred Language: ___English
___Chinese
___ French
___Italian
___ Spanish
___ Vietnamese

Ethnicity: ___ Caucasian
___ Hispanic
___ Non-Hispanic

Were you referred by another Physician: Yes ___ No ___ Physician's Name: _____

Is this related to an accident? Yes ___ No ___ If yes, what was the date of the injury? _____/_____/_____

Is this related to a Workman's Compensation Claim? Yes ___ No ___

RESPONSIBLE PARTY, IF OTHER THAN PATIENT

Last Name: _____ First Name: _____ SSN: _____

Address: _____ City: _____ St: ____ Zip code: _____

Phone: (____) _____ Employer: _____ Work Phone: (____) _____

ENT
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INSURANCE INFORMATION

PRIMARY INSURANCE

Company: _____

Policy Number: _____

Group Number: _____

Policy Holder: _____

Policy Holder D.O.B. _____

Policy Holder Employer: _____

_____

SECONDARY INSURANCE

Company: _____

Policy Number: _____

Group Number: _____

Policy Holder: _____

Policy Holder D.O.B. _____

Policy Holder Employer: _____

_____

I hereby authorize ENT Associates of Tuscaloosa, P.C. to disclose complete information acquired in the course of my examination(s) to be released to my referring physician. I also hereby authorize ENT Associates of Tuscaloosa, P.C. to disclose complete information concerning medical findings, treatment and charges incurred to my medical insurance carrier or third party, and assign all payments to ENT Associates of Tuscaloosa, P.C. for medical services to myself or my dependents.

I understand that some procedures provided by ENT Associates of Tuscaloosa, P.C. may not be covered by my insurance. I agree that I am responsible for payment of any amount not paid by my insurance. If my account becomes delinquent for more than sixty (60) days, I agree to pay all attorney's fees, court costs, and any other reasonable cost of collections should I fail to pay for these non-covered charges.

As a courtesy to our patients, we will file claims for our services with most insurance carriers. The exceptions to this are any commercial carrier who does not provide adequate information to us for filing, or any carrier with which we do no have a contractual agreement. We will gladly supply you with an itemized statement for your insurance; however, we will expect payment in full at the time of the service.

At the time of service, you will be responsible for either your copay or any amount you may owe which is determined by your policy. If you do not have insurance, payment in full is expected at the time of service.

Our entire office is dedicated to providing you with the best care possible. If you have any questions, please do not hesitate to ask us. Thank you.

_____ _____

Signature of patient (or responsible party) Date

PAST MEDICAL HISTORY

Many ear, nose, and throat problems or treatments are affected by other health problems or medications. Please help us by answering the following questions.

Primary Care Physician: _____

Have you ever had any of the following health conditions? (please check all that apply)

- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Paralysis
- ☐ Severe Headaches
- ☐ Seizures
- ☐ Blackout Spells
- ☐ Head Injury
- ☐ Meningitis

- ☐ Asthma
- ☐ Emphysema
- ☐ Cough Up Blood
- ☐ Tuberculosis
- ☐ Pneumonia (requiring hospitalization)
- ☐ Severe Heart Burn
- ☐ Hiatal Hernia
- ☐ Stomach Ulcers
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Infection
- ☐ Thyroid Problems

- ☐ Diabetes
- ☐ Arthritis/Joint Pain
- ☐ Prolonged fever
- ☐ Unplanned Weight Loss
- ☐ Enlarged Lymph Nodes
- ☐ Free Bleeding
- ☐ Blood Thinner Treatment
- ☐ Anesthesia Problems
- ☐ Cancer
  Type: _____
  Treatment: _____
  _____
  _____

Are you ALLERGIC to? (please check all that apply)

- ☐ Penicillin
- ☐ Sulfa
- ☐ "Mycins"
- ☐ Aspirin
- ☐ Codeine
- ☐ Tetanus
- ☐ Demerol
- ☐ Other: _____
  _____
  _____
  _____

Are you a current everyday smoker? ____ No ____ Yes Amount_____ Years_____
Are you a former smoker? ____No ____ Yes Amount_____ Years_____
Do you drink alcohol? ____No ____Occasionally ____Everyday ____Socially

Do you have any other health problems that are not listed above? If so, please list below:

_____

_____

_____

Please list any operations you have had:

Operation	Date	Surgeon	Hospital

Have any of your blood relatives ever had any of the following conditions?
(Place an "X" in box for relative that applies)

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergy										
Heart Disease										
High Blood Pressure										
Stroke										
Diabetes										
Bleeding Problems										
Tuberculosis										
Cancer										
Anesthesia Problems										
Hearing Loss										

Please list any medications you are now taking, including dosage.
(Including non-prescription medications)

_____

_____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please list below any individual(s) you would like us to release information to regarding your care and treatment. Please note, we will not be able to relay any information regarding your medical care with any person not listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices of Ear, Nose, & Throat Associates of Tuscaloosa, P.C. (Copy located at the front desk window)

Patient Signature: _____ Date: _____

NOTICE OF NONDISCRIMINATION

Ear, Nose, and Throat Associates of Tuscaloosa, PC, Dr. Salem K. David Jr., does not discriminate against any person on the basis or race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, please contact our Practice Administrator at (205) 333-3330.