Date: ____/____/____

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? ____/____/____

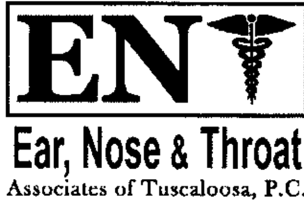
Is this related to a Workman's Compensation Claim? Yes ___ No ___

RESPONSIBLE PARTY, IF OTHER THAN PATIENT

Last Name: ______________ First Name: ______________ SSN: ______________

Address: ______________ City: ______________ St: ___ Zip code: ______

Phone: (___) ______________ Employer: ______________ Work Phone: (___) ______________



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

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Company: ________________	Company: ________________
Policy Number: ________________	Policy Number: ________________
Group Number: ________________	Group Number: ________________
Policy Holder: ________________	Policy Holder: ________________
Policy Holder D.O.B. ________________	Policy Holder D.O.B. ________________
Policy Holder Employer: ________________	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

PEDIATRIC EAR, NOSE & THROAT HISTORY

What problem is your child having? ____

____

Please check problems that apply to your child.

EARS:

- ☐ Ear Infections
  Number per year ____
  - ☐ Related hearing loss
  - ☐ Related Fever
  - ☐ Related Ear Pain
  - ☐ Drainage
    Antibiotics used:
    ____
    ____
    ____
- ☐ Injury to Ear
  ___Right ___ Left
- ☐ Hearing Loss
  Age at which this was first noticed______
  - ☐ Family history of childhood hearing loss
  - ☐ Mother had infection during pregnancy
  - ☐ Low birth weight (less than 1500 grams)
  - ☐ APGAR score (at birth) of less than 3
  - ☐ Child with infection at birth
  - ☐ High bilirubin/jaundice (more than 15 mg/dl) after birth
  - ☐ Bacterial meningitis (infection of nervous system)
- ☐ Speech Delay
- ☐ Wears Hearing Aid ___ Right ___ Left
- ☐ Dizziness/Imbalance
- ☐ Previous Ear Surgery ___ Right ___ Left
  Type: ______________________________
- ☐ Other: ______________________________
  ____
  ____

NOSE AND SINUSES:

- ☐ Stuffiness/Blockage
  ___ Right ___ Left
- ☐ Nasal Drainage
  - ☐ Clear
  - ☐ Yellow
- ☐ Post Nasal Drip
- ☐ Swelling around the eyes
- ☐ Snoring
- ☐ Nosebleeds
  ___ Right ___ Left
- ☐ Injury to Nose
- ☐ Sinus Infections
  Number per year ____
  Antibiotics used:
  ____
  ____
  ____

THROAT:

- ☐ Sore Throat
  ____ Strep Infections ____ Tonsillitis
  Number per year ______
  Antibiotics used: ______________________
  ____
  ____
- ☐ Cough
  ____ Daytime ___Mostly Night
- ☐ Mouth Breathing
- ☐ Bad Breath
- ☐ Hoarseness
- ☐ Swollen Glands
- ☐ Other: ______________________________

PEDIATRIC 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:

Allergies (please check all that apply)

- ☐ Penicillin
- ☐ Sulfa
- ☐ Ceclor
- ☐ Codeine
- ☐ Tetanus
- ☐ Other: ________________

____

____

Please list ANY medications that your child is now taking (including non-prescription medications)

____

____

____

____

____

____

____

____

Has your child ever had any of these conditions?
(please check all that apply)

____ Heart Problems
____ Asthma
____ Pneumonia requiring hospitalization
____ Other Lung Problems
____ Meningitis (Nervous System Infection)
____ Jaundice
____ Kidney Problems
____ Diabetes
____ Free Bleeding
____ Attends Day Care
____ Parent(s) Smoke
____ Seizures
____ Sickle Cell Disease
____ Other: ________________

____

Please list ANY operations that your child has had: ____

____

____

Has any blood relative ever had any of these conditions?
(please check all that apply)

____ Allergies
____ Anesthesia Problems
____ Stroke
____ Bleeding Problems
____ Hearing Loss
____ Diabetes
____ Tuberculosis
____ Heart Disease
____ High Blood Pressure

Other: ____

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., and Dr. Pamela R. Hanson, 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.