Ear, Nose, Throat, and Allergy of Florida – Patient Information

Please Fill Out Form Completely

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

Salutation: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name: ____ Date of Birth:____________________ Age:_________

Sex: F____ M ____ Marital Status: 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 consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Ear, Nose & Throat Associates of South Florida, PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and Ear, Nose, Throat, and Allergy of Florida to photograph me for medically related documentation purposes. Yes______ No_______

Signature:____**Date**:____

MEDICAL HISTORY FORM

Patient Name: ___________________________ Date of Birth: ___________________ M or F

Briefly, why are you seeing our physician today? ___________________________

Primary Care/ Referring Physican___________________ **Pharmacy**___________________

Height:__________ **Weight:**______________

1. **Social History -** 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).

2.Surgeries - Please list any surgeries and hospitalizations: ___________________________

____

3.Patient History - Please check your response

	Yes	No
Cancer	( )	( )
Heart/Pacemaker	( )	( )
Cardio: Hypertension	( )	( )
Ear: Dizziness	( )	( )
Ear: Hearing Loss	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )
Endocrine: Diabetes	( )	( )
Endocrine: Thyroid Disorders	( )	( )
G.I.: Bowel Disorders	( )	( )
G.I.: Liver Disorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )
Immuno: Hepatitis	( )	( )
Immuno: HIV	( )	( )
Immuno: Immune Dieases	( )	( )
Lymph: Anemia	( )	( )
Lymph: Bleeding Disorders	( )	( )

	Yes	No
Nasal: Allergies	( )	( )
Nasal: Nasal Tramua	( )	( )
Nasal: Nose Bleeds	( )	( )
Nasal: Sinusitis	( )	( )
Neuro: Headaches/Migranes	( )	( )
Neuro: Nervous System	( )	( )
Neuro: Seizure Disorder	( )	( )
Ophth: Eyes/Glaucoma	( )	( )
Oral: Sleep Apnea	( )	( )
Pysch: Psychiatic Disorders	( )	( )
Pulm: Lungs	( )	( )
Pulm: Asthma	( )	( )
Pulm: Tuberculosis	( )	( )
Uro:Bladder Disorders	( )	( )
Uro: Kidney	( )	( )

Other: ___________________________

4. **Family History -** Please check your response

	Yes	No
Allergies	( )	( )
Cancer	( )	( )
Diabetes	( )	( )
Headaches/Migraine	( )	( )
Immune Disease	( )	( )

	Yes	No
Premature Hearing Loss	( )	( )
Sinusitis	( )	( )
Sleep Apnea	( )	( )
Thyroid Disorders	( )	( )

Details of Yes answers:___________________________

____

Patient Signature:___________________________ Date: ______________

DANIEL GANC, MD
BOARD CERTIFIED
OTOLARYNGOLOGY
SINUS | ALLERGY

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

MESSAGE CONSENT

It is our policy to notify you of all test results ordered by this office and to confirm appointments. This is acknowledge that you authorize us to leave a detailed message on voicemail/answering machine.

Yes ________ No ________ Patient/Guardian Signature: ____________________________

DANIEL GANC, MD
BOARD CERTIFIED
OTOLARYNGOLOGY
SINUS | ALLERGY

Payment Policy

Please read and sign this form as it concerns you, the patient.

*****YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY**

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. I**t is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether or not we are providers for your specific network.**

- **Referrals**

If you need a referral from your insurance company or from your primary care physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us.

- **Non-Participating Provider Policy**

If we are not a provider for your insurance company, we will collect our fee in full at the time of service.

- **Your Financial Responsibility**

You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at the time of service. Because we are specialists, some diagnostic/invasive procedures are not considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense.

____ ___________________________

Patient Signature Date

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 Ear, Nose & Throat Associates of South Florida 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 and co-pays, and that payments are due at the time of services are 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 or collection agency and I agree to pay the collection agency's fees for collection, any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Patient Signature ______________________________________ Date _________________

Privacy Consent

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

Patient Signature ______________________________________ Date _________________

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT Associates of South Florida, PA., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, CT's, allergy testing and treatment, and administration of medications prescribed by the physician.
I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Patient Signature ______________________________________ Date _________________

Medicare Consent

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 Signature ______________________________________ Date _________________

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Acknowledgement Form

In order to provide clinically appropriate Ear, Nose and Throat services, we often feel that patients presenting to our office can benefit from diagnostic testing. This frequently consists of a nasal endoscopy (evaluation of nose and sinuses), fiberoptic laryngoscopy (evaluation of voice box and throat) or nasopharyngoscopy (evaluation of the back of the nose and Eustachian tubes). This requires the doctor to use a type of telescope to better evaluate the inside of either the nose, throat or voice box. As a convenience for our patients, this is typically done at the same time as the office visit.

These procedures may come as a separate charge from the office visit. The cost associated with these procedures can range from **$150-$300 or more** depending on your insurance. In many cases this will be covered by the insurance provider with no additional out of pocket expense to the patient. However, some insurance plans will require patients to pay a separate co-payment or deductible.
Please note some insurance companies may list these diagnostic procedures as “surgery” on the explanation of benefits form.

Be advised that this scope procedure may not be indicated for your visit today. The signing of this form is simply acknowledging in the event a scoping procedure is required there may be an additional associated cost that will be collected at time of service.

______________________________ ____________
Patient Name DOB

______________________________ ____________
Patient/Guardian Signature Date

Nasal Obstruction Evaluation Survey

PATIENT NAME: ______________________ DATE: ______________

Over the past ONE month, how much of a problem were the following conditions for you? Please circle the most correct response for each category.

SYMPTOM ASSESSMENT

	Not a Problem	Very Mild Problem	Moderate Problem	Fairly Bad Problem	Severe Problem
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through my nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

TOTAL x5= [ ]

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