Patient History and Physical Exam (New Patient)

Name_____ Age_____ DOB_____ DATE_____

HEIGHT_____ WEIGHT_____ LAST BLOOD PRESSURE IF KNOWN _____

DO YOU HAVE ANY DRUG ALLERGIES? ☐ YES ☐ NO Please List _____

MEDICATION LIST: Please list any medications and dosages (if known that you are currently taking. Be sure to include **Aspirin**, multivitamins, and any other over-the-counter medications. If you have an extensive list, you can ask the nurse to copy it for you instead of re-writing the information here.

Are your immunizations, including Tetanus up to date? ☐Yes ☐No Date of last Tetanus Shot (if known)_____

History of Present Illness

What is your Chief Complaint?_____

When did this first start? _____ Has it changed? ☐ YES ☐ NO If yes, how?_____

Has this ever happened before? ☐ Yes ☐ No Were you treated for this in the past? ☐ Yes ☐ No

If Yes, what treatment or medications? _____

Is there a family history of similar problems?_____

PMH

MEDICAL PROBLEMS: Have you ever been diagnosed with our treated for any of the following (check all that apply)

☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐ Asthma
☐ Ear Problems	☐ Sinus Problems	☐ Migraine Headaches	☐ Emphysema
☐ GERD	☐ Kidney Problems	☐ Thyroid Disease	☐ Rheumatoid Arthritis
☐ Heartburn	☐ Neurological Problems (stroke, seizure, etc.)		

☐ Other _____

What surgeries have you had in the past?_____

Family History Do you have a family history of ☐ Seasonal Allergies, ☐ Asthma, ☐ Other Disease? _____

Social History What is your occupation?_____

If you are retired, what was your occupation?_____

Personal Habits: Do you smoke or chew? ☐ Yes ☐ No If yes how much?_____ How Long? _____
If you have quit using tobacco, when did you quit and for how long did you use the product? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often?_____

COMPLETE REVERSE SIDE

Constitution

☐ Chills

☐ Fever

☐ Weight Loss

Eyes

☐ Vision Changes

☐ Double Vision

Ears

☐ Ear Discharge
RT ☐ LT ☐ BIL ☐

☐ Hearing Loss
RT ☐ LT ☐ BIL ☐

☐ Ear Pain
RT ☐ LT ☐ BIL ☐

☐ Ringing
RT ☐ LT ☐ BIL ☐

☐ Vertigo

Nose

☐ Chronic Runny Nose

☐ Congestion

☐ Nose Bleeds
RT ☐ LT ☐ BIL ☐

☐ Post-Nasal Drip
RT ☐ LT ☐ BIL ☐

☐ Sinus Pain

Throat/Mouth

☐ Dental Problems

☐ Hoarseness

☐ Snoring

☐ Difficulty Swallowing

☐ Pain with Swallowing

☐ Sore Throat

☐ Mouth Ulcers

☐ Sleep Apnea

Respiratory

☐ Asthma

☐ Chest Pain

☐ Chest Tightness

☐ Cough

☐ Cough with Blood

☐ Cough with Mucous

☐ Pneumonia

☐ Wheezing

GI

☐ Changes in Bowel Habits

☐ GERD

☐ Heartburn

☐ Nausea

☐ Stomach Ulcers

☐ Vomiting

Skin

☐ Abnormal Growths

☐ Changing Moles

☐ Rash

☐ Sores

Neurology

☐ Headaches

☐ Depression

☐ Seizures

PLEASE CHECK ALL THAT APPLY:

Endocrine

☐ Diabetes

☐ Goiters

☐ Cold Intolerance

☐ Heat Intolerance

☐ Thyroid Problems

Hematologic/Lymphatic

☐ Anemia

☐ Easy Bleeding

☐ Easy Bruising

☐ History of cancer or HIV

☐ Swollen Glands
RT ☐ LT ☐ BIL ☐

Allergy/Immunology

☐ Seasonal Allergies

COMPLETE REVERSE SIDE

Registration and HIPPA

Section I: PATIENT INFORMATION Date _____

Last Name _____ First _____ MI _____

Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Height _____ Weight _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Social Security Number _____

Date of Birth _____ AGE _____ Male ☐ Female ☐

Pharmacy you want us to use _____

Place of employment _____ May we contact you at work? Yes ☐ No ☐

Primary Care Physician _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Email Address _____ May we contact you via email? Yes ☐ No ☐

May we send statements via email? Yes ☐ No ☐

Section II: INSURANCE #1 RESPONSIBLE PARTY

Name of Insured _____ DOB _____

SSN#: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

Name of Employer _____ Work Phone: (_____) _____

Section III: INSURANCE #2 RESPONSIBLE PARTY

Name of Insured _____ DOB _____

SSN#: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

Name of Employer _____ Work Phone: (_____) _____

Please list anyone you allow us to release information to, and their relationship to you:

NAME _____ **RELATIONSHIP** _____

NAME _____ **RELATIONSHIP** _____

Acknowledgement of Receipt of Notice and Consent to use and disclose health information.

This acknowledgement of notice and consent authorizes Peter White, MD to use and disclose health information about you for treatment, payment and health care operation purposes. Notice of Privacy Practices: Peter White, MD has a Notice of Privacy Practices which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practice and make the terms of any change effective for all protected health information that we maintain including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our office.

I have received the notice of Privacy Practices for Peter Whiter, MD. Peter White, MD is authorized to use and disclose health information about patient listed above for treatment, payment, and health care operations consistent with this Policy. I also acknowledge the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Peter F. White, MD or the insurance company to release any information required to process my claims.

Signature of Patient or Representative _____ Date: _____

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about out fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST A PHOTOCOPY OF YOUR INSURANCE CARD(S) FOR OUR FILE.

APPOINTMENTS - 24 hours' notice must be provided in the event you cannot keep an appointment. If you do not provide this notice, a no show fee of $25 may then be added to your account and must be paid before a new appointment is scheduled. If you are scheduled for a lengthy appointment such as an Allergy Test, VNG, ENG, ABR, or OAE and do not provide notice of cancellation, we may discharge you from the practice in addition to the $100 no show fee. This fee is not billable to any insurance company and is the sole responsibility of the patient.

REFERRALS - If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment. If you do not have your referral, **YOU WILL BE ASKED TO RESCHEDULE** your appointment.

FEES - We provide comprehensive Otolaryngology care including office visits, consultations, in-office procedures, allergy and audiology services. Many of our services have separate fees.

INSURANCE

It is your responsibility to understand your benefit plan. Not all services provided by our office are covered by every insurance plan. You are responsible for all co-pays, deductibles, co-insurances, cost-share, and non-covered services. If your insurance carrier determines that you are not eligible for benefits, you are financially responsible for all charges.

> **Private Insurance Authorization for Assignment of Benefits/Information Release:** I, the undersigned, authorize payment of medical benefits to Peter F. White, M.D. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim of benefits.

CO-PAYMENTS - By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

OUT OF NETWORK PLANS - Since you decided to go out-of-network for medical treatment you may be responsible for higher out-of-pocket expenses. Our office will submit charges to your insurance carrier on your behalf. However, if they do not pay your claim within 45 days, you will be responsible for the full amount due. If you received payment from your insurance carrier, please forward it to our office.

PLEASE COMPLETE REVERSE SIDE AND SIGN

SELF-PAY PATIENTS - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE - We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which will be billed to a secondary insurance if you are covered under a supplemental plan.

> **Medicare Lifetime Signature on File:** I request that payment of authorized Medicare benefits be made on my behalf to Peter F. White, M.D. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it's agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims.

MEDICAL ASSISTANCE - You must first see your Primary Care Physician and be referred for initial treatment at this office. We treat patients with Medical Assistance that reside in the same counties that we are located (Crawford and Mercer).

DIVORCED/SEPARATED PARENTS OF MINORS - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Peter F. White, M.D. will not be involved with separation or divorce disputes.

NO-FAULT/WORKERS COMPENSATION - It is your responsibility to provide our office with necessary information to submit a claim. If they deny your claim, we will submit to your private insurance provided you have obtained the required referrals.

FORMS FEE - There is a $15 fee per form to complete Disability Insurance and Family Medical Leave Act forms. You must complete your section of the form, sign an authorization to release information, and prepay the $15 fee.

WE ACCEPT CASH, CHECKS, MASTER CARD, VISA AND MONEY ORDERS.

A $30 fee will be charged for any checks returned for insufficient funds.

I have read and/or been advised to read the entire Financial Policy. I agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name *(Please Print)* _____

_____ _____

Responsible Party's Name *(Please Print)* **Relationship**

_____ _____

Responsible Party's Signature **Date**