Patient History and Physical Exam (New Patient)

Name______________________ Age________ DOB____________ Date ____________

Family Doctor or PCP ______________________ Did they refer you here today? ☐ Yes ☐ No

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? ______________________

Review of Systems: Have you recently experienced any of the following (check all that apply)

General	***Ears***	***Nose***	***Throat / Mouth***	***Neck***
☐ Fever / Chills	☐ Hearing Loss	☐ Nose Bleeds	☐ Hoarseness	☐ Stiffness
☐ Headache	☐ Ear Pain	☐ Runny Nose	☐ Snoring / Sleep Apnea	☐ Swollen Glands
☐ Weight Loss	☐ Ear Discharge	☐ Congestion	☐ Sore Throat / Mouth Ulcers	***Skin***
Eyes	☐ Ringing	☐ Sinus Pain	☐ Difficulty Swallowing	☐ Rash or Sores
☐ Vision Changes	☐ Dizziness	☐ Post-nasal Drip	☐ Pain with Swallowing	☐ Changing Moles
☐ Double Vision	☐ Vertigo	☐ Seasonal Allergies	☐ Dental Problems	☐ Abnormal Growths

Chest	***Abdomen***	***Endocrine***	***Hematologic***
☐ Wheezing or Asthma	☐ Heartburn or GERD	☐ Thyroid Problems	☐ Anemia
☐ Cough (blood or mucus?)	☐ Stomach Ulcers	☐ Diabetes	☐ Easy Bleeding / Bruising
☐ Pneumonia	☐ Changes in Bowel Habits	☐ Goiter	☐ History of Cancer or HIV
☐ Chest Pain / Tightness	☐ Nausea / Vomiting	☐ Heat / Cold Intolerance	☐ Swollen Lymph Nodes

Past Medical History: Have you ever been diagnosed with or treated for any of the following (check all that apply)

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

☐ Other______________________

What surgeries have you had in the past?______________________

Do you have any known **DRUG ALLERGIES**? ☐ Yes ☐ No Please list ______________________

Do you have any seasonal allergies (grasses, pollen, etc.) ____________ Have you ever had allergy testing? ☐ Yes ☐ No

Do you have a **Family History** of seasonal allergies, asthma or other disease? ______________________

Social History: Do you Smoke or Chew? ☐ Yes ☐ No If Yes, how much?__________ For 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?______________

What is your occupation?______________ Married / Single (circle one) # children________

If you are retired, what was your occupation? ______________________

Please complete both sides where indicated.

Patient History and Physical Exam (New Patient)

Name______________________ Age__________ ALLERGIES:______________________

Medications:

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)______________

~ STOP ~ DO NOT WRITE BELOW THIS POINT ~ STOP ~

Patient History and Physical Exam (New Patient)

Male / Female	Normal	Abnormal
Constitutional		
• Appearance / Development	☐	
• A & O x 3	☐	
• Acute distress?	☐	
• Voice Quality / Communication	☐	
Head / Face		
• Appearance (deformity, scars?)	☐	
• Palpation sinuses	☐	
• Parotid / Submandibular glands	☐	
• Facial strength	☐	
Ears		
• External appearance	☐	
• EACs	☐	
• TMs (fluid, retractions or perf)	☐	
• Speech recognition (whisper)	☐	
• Tuning fork (Weber, Rinne)	☐	
Eyes		
• Ocular motility / gaze	☐	
Nose / Nasopharynx		
• External appearance	☐	
• Mucosa	☐	
• Septum	☐	
• Turbinates	☐	
• Adenoids / posterior nasopharynx	☐	
Oral Cavity		
• Lips	☐	
• Teeth	☐	
• Gingiva	☐	
• Hard / Soft palate / uvula	☐	
• Tongue	☐	
• Tonsils	☐	
• Post-Pharynx	☐	
Larynx (Mirror Exam)		
• Epiglottis	☐	
• Hypopharynx	☐	
• Base of Tongue	☐	
• Pyriform Sinuses	☐	
• False Cords	☐	
• True Cords	☐	
• Posterior Commissure	☐	
• Arytenoids	☐	
* Circle if unable to tolerate mirror due to gag reflex		
Neck		
• Appearance / Symmetry	☐	
• Lymph nodes (II-V)	☐	
• Thyroid (enlarged, mass, etc.)	☐	

	Normal	Abnormal
Cardiovascular		
• Auscultation	☐	
• Peripheral Vascular	☐	
Respiratory		
• Auscultation	☐	
• External inspection	☐	
Neuro / Psyche		
• Cranial Nerves II-XII	☐	
• Mental Status	☐	
• Mood / Affect	☐	
Derm		
• Skin rash or lesions?	☐	

Audio Findings:______________________

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Scope Findings:______________________

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Clinical Impression: ______________________

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Plan: ______________________

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Signature: ______________________

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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.

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**

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: ____________