Wilmington Ear Nose & Throat Associates, PA ***Patient Information Form***

Patient Name: _____
Last First Middle

Mailing Address: _____

Street Address (if different from above): _____

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

Phone#: _____ Cell#: _____ Work#: _____ Employer: _____

Email: _____

Date of Birth: _____ Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Needed For Insurance Filing Only

Spouse's Name: _____ Social Security #: _____ Date of Birth: _____

Spouse's Employer: _____ Spouse's Employer's Phone#: _____

Guarantor (Responsible Party) for patients under 18 years of age OR if the patient is not the primary policyholder.

Guarantor's Name**:** _____
Last First Middle

Mailing Address: _____

Street Address (if different from above): _____

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

Phone#: _____ Cell#: _____ Work#: _____ Employer: _____

Date of Birth: _____ Sex: ☐Male ☐Female Relationship to Patient: _____

Responsible Party for patients under 18 years of age

Father's Name: _____ Mother's Name: _____

Father's Social Security#: _____ Mother's Social Security#: _____

Father's Date of Birth: _____ Mother's Date of Birth: _____

Father's Employer: _____ Mother's Employer: _____

Employer's Phone#: _____ Employer's Phone#: _____

Insurance Information ****** Please complete in full to ensure proper billing of services ******

Relationship to Primary Insured: ☐Self ☐Spouse ☐Child ☐Other (explain): _____

Primary Carrier: _____

Secondary Carrier: _____

Tertiary Carrier: _____

Please provide all insurance carrier membership ID cards **&** a government issued photo ID to the receptionist at the time of check-in.

General Information

Race: ☐ American Indian / Native Alaskan ☐ Asian ☐ Black / African American
☐ Native Hawaiian /Pacific Islander ☐ Other Race ☐ White ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Emergency Contact: _____ Relationship: _____ Phone#: _____

Referring Physician: _____ Primary Physician: _____

Pharmacy: _____ Location: _____ Phone#: _____

Authorization to pay benefits to Physician

I hereby authorize payment directly to the physician of surgical and medical benefits, if any, otherwise payable to me for this service as described including Medicare Benefits. I further authorize the release of medical information about me to process my medical claims in accordance with the Notice of Privacy Practice furnished to me.

Signature: _____ Date: _____

Acknowledgement of notice of Privacy Practices

The undersigned hereby acknowledges that upon request I may receive of a copy of the Notice of Privacy Practices of Wilmington Ear Nose & Throat Associates, PA.

Signature: _____ Date: _____

Wilmington Ear Nose & Throat Associates, P.A.

Authorization to Release and Obtain Medical Information

Name:_____ Date of Birth:_____

Social Security #:_____ Telephone #:_____

Please list any person(s) or organization(s) you authorize to have access to your medical information (Family members(s), or other physicians, etc.). Because of the HIPAA (Health Insurance Portability &Accountability Act of 1996) rules & regulations, we cannot divulge any information unless you designate that person to receive such information.

Types of Medical Information may include, but not limited to:

Clinical Chart Notes Medication Lists Lab Reports Diagnostic Studies Pathology Reports

Person(s) that I authorize access to my medical information are:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I hereby authorize Wilmington Ear Nose & Throat Associates, P.A. to obtain any information needed in the course of my treatment, as well as release any information needed or obtained in the course of my treatment to physicians and/ or other medical providers where treatment is, or may be rendered, as well as the person(s) listed above. I also hereby authorize my physician to release any information required in the course of my treatment to process insurance claims.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail, answering system, or another individual if I am unavailable at the number provided by me.

Signature:_____ Date:_____

The above authorization(s) will remain in effect unless notification is made to us by you in writing.

Wilmington Ear Nose & Throat Associates, P.A.

Health History Questionnaire

Date:_____

Patient Name: _____ DOB: _____

Reason for Today's Visit: _____

Referring Physician: _____ Primary Care Physician:_____

PAST MEDICAL HISTORY: (Please check **ALL** that apply)
Do you have or have been treated for any of the following?

☐ AIDS/HIV	☐ Bleeding Disorder	☐ Arthritis	☐ Allergies
☐ Depression	☐ Heart Disease/Attack	☐ Sickle Cell	☐ Asthma
☐ Liver Disease	☐ High Blood Pressure	☐ Seizures	☐ Diabetes
☐ Kidney Disease	☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Meningitis
☐ Thyroid Disease	☐ Cancer (Type: _____)	☐ Cataracts	☐ Stroke
☐ Stomach Ulcers	☐ Transplant (Type: _____)	☐ Ear Disease (Specify)	☐ High Cholesterol
☐ Hepatitis	☐ Tuberculosis (TB)	☐ Other:_____	☐ Sleep Apnea

SURGERIES: (Please List)

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

ALL CURRENT MEDICATIONS: (INCLUDING VITAMINS, HERBS, AND OVER-THE COUNTER)

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
Medication	Dosage	Medication	Dosage
_____	_____	_____	_____

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY FOODS, MEDICATIONS OR VITAMINS? ☐ YES ☐ NO

If YES, please list the food(s), medication(s) and/or vitamin(s) and describe the reaction:

Name	Reaction	Name	Reaction
_____	_____	_____	_____
Name	Reaction	Name	Reaction
_____	_____	_____	_____

FAMILY HISTORY: (Please check **ALL** that apply to your ***family members***)

☐ Hearing Loss	☐ Cystic Fibrosis	☐ Sinus Disease	☐ Allergy/Asthma	☐ Stroke
☐ Heart Disease	☐ Hypertension	☐ Cancer	☐ Bleeding Disorder	☐ _____

*****PLEASE CONTINUE ON PAGE 2*****

Wilmington Ear Nose & Throat Associates, P.A.

SOCIAL HISTORY & HEALTH BEHAVIORS

What is your occupation? _____

Have you ever smoked cigarettes, cigars or a pipe? ☐ YES ☐ NO

If you have stopped smoking, when did you quit? _____

How long did you smoke? _____ years

If you still smoke, how much do you smoke per day? _____ packs per day

Do you drink alcohol? ☐ YES ☐ NO

If YES, how much do you drink per week? _____

Have you ever used any addictive substances or drugs? ☐ YES ☐ NO

If YES, list the substances and when you last used them. _____ _____ _____

REVIEW OF SYSTEMS: Check **ALL** of the following that you have now

GENERAL

- ☐ Nausea
- ☐ Recent Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever / Chills / Night Sweats

SLEEP DISTURBANCE

- ☐ Loud Snoring
- ☐ Excessive Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Breathing Stops During Sleep
- ☐ Wake up Feeling Tired

CARDIOPULMONARY

- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest Tightness

NERVOUS

- ☐ Numbness
- ☐ Tingling
- ☐ Fainting
- ☐ Weakness

PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Depression

ABDOMINAL

- ☐ Diarrhea/Constipation
- ☐ Abdominal Pain

EARS

- ☐ Ringing
- ☐ Hearing Loss
- ☐ Dizziness / Vertigo
- ☐ Pain
- ☐ Fullness / Pressure
- ☐ Drainage

MOUTH / THROAT

- ☐ Soreness
- ☐ Ulcers
- ☐ Difficulty Swallowing
- ☐ Lumps in Neck
- ☐ Painful Swallowing
- ☐ Hoarseness
- ☐ Choking

ENDOCRINE

- ☐ Temperature Intolerance
- ☐ Excessive Thirst

EYES

- ☐ Change in Vision
- ☐ Clouded Vision
- ☐ Dry Eyes
- ☐ Double Vision

GASTROINTESTINE

- ☐ Indigestion
- ☐ Heartburn
- ☐ Vomiting
- ☐ Change in Stool

Patient ID #_____

Wilmington Ear Nose & Throat Associates, PA

E-Prescribing Consent Form

The providers at Wilmington Ear Nose & Throat Associates, PA use an electronic medical record system (EMR) that permits our providers to prescribe medications electronically. This capability is known as ePrescribing and is defined as a physician's ability to electronically send an accurate and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to send prescriptions electronically is an important element in improving the quality of patient care. This process helps reduce medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Wilmington Ear Nose & Throat Associates, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wilmington Ear Nose & Throat Associates, PA to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient (*or Guardian*) Date

_____

Relationship to Patient

_____ _____ _____

Preferred Pharmacy Name Pharmacy Location Pharmacy Telephone Number

Patient ID #_____

Wilmington Ear Nose & Throat Associates, PA

Patient Portal Authorization Form

The patient portal offers patients of Wilmington Ear Nose & Throat Associates, PA a secure way to view parts of their healthcare records. Please read this form thoroughly before signing to request access to view your medical records on the patient portal.

Wilmington Ear Nose & Throat utilizes a patient portal that uses computer security to keep unauthorized persons from reading information or attachments. Health information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal, you will have access to only your records or those for whom you are legally responsible.

This method of communicating, and viewing, prevents unauthorized parties from being able to access your private health information. However, keeping health information secure depends on two important factors: we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.

The Patient Portal will allow you to:

- View health summary information in your electronic record: medication list at time of visit, medical problem list, allergies, and some of your laboratory results. This portal will not give you access to read your entire medical record.
- View and update demographic / insurance information.
- View, cancel or request an appointment.

To participate, please provide a copy of your photo ID and this form. Once this form is signed and approved, you will receive an invitation to your personal e-mail with instructions on setting up your user name and password for the patient portal.

Conditions of Participating in the Patient Portal:

We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service, and we may suspend or discontinue it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree NOT to:

1) Transmit any electronic information that violates the rights or privacy of any party.

2) Use the web portal in any way that would violate local, state or federal laws.

3) Transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.

4) Intentionally distribute software/computer viruses or take any other action that could compromise the security of our computer system.

_____ _____

Patient Name | Relationship to Patient (if Legal Guardian)

_____ _____

Confidential Email Address | Date of Birth of Portal User

_____ _____

Signature of Patient (*or Legal Guardian*) | Date

*** If you have Medicare or are at least 65, you must complete this form. ***

Wilmington Ear Nose & Throat Associates, P.A.

Medicare Patient Registration Form

****Please fill out this form completely****

*****Please present your insurance card(s) for copies to be made*****

Name: _____ Social Security #: _____
(**Internal Use Only**)

Who referred you to Wilmington Ear Nose & Throat? _____

Please answer all questions below by placing a check in the appropriate column:

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? ☐ Yes ☐ No

Have you signed up for a Medicare replacement policy? ☐ Yes ☐ No

If yes, identify: _____

Are you receiving Medicaid? ☐ Yes ☐ No

Are you a resident of a Skilled Nursing Facility? ☐ Yes ☐ No

If yes, Name of Facilty: _____ City:_____

Are you under Hospice Care? ☐ Yes ☐ No

If yes, please list your attending physician: _____

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature as it appears on Card Date

If you have another policy, we are required to keep a separate signature on file. Your signature below indicates authorized benefits are paid, on your behalf, by the supplemental carrier named below:

Name of other insurance carrier: _____ ☐ Primary ☐ Secondary

Name of policy holder: _____

Social Security # of policy holder: _____ Date of Birth of policy holder: _____

I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature as it appears on Card Date