Andrea M. Williams, MD
www.docsinus.org

Information – Confidential

Patient Name:____Date:_______________________________

SSN____________________ Birthdate_______________________ Age: _______ Gender: _____ Male ____Female

Address__________________________________ City_______________________ State________ Zip___________

Home Phone_____________________________ Email Address____

Cell Phone________________________________ Other Phone____

Check appropriate box: __ Minor __ Single __ Married __ Separated__ Divorced __Widowed

What is the Reason for your visit today? _____________________________________

How were you referred to our office? __ Internet
__ Insurance book
__ Friend / Relative _______________________________
__Primary Care Physician

Who is your Primary Care Physician? _________________________________Address/Phone ___________________

If Referred, Name of Referring Provider _______________________________ Address/Phon ___________________

Person to contact in case of emergency______________________________________ Phone___________________

Pharmacy Information

Name of your Pharmacy_________________________ Address / Location____________________________

Phone Number ________________________________ Fax Number _________________________________

Insured Party Information (policy holder)

Name of insured____

Relationship to patient_________________________ Birthdate_________________

Social Security#___________________________ Date employed____________________

Name of employer____ Work phone______________________

Insurance company______________________________ ID #___________________________ Group #______________

Insurance co. address_________________________________ City___________________ State________ Zip_________

How much is your office visit co-pay/co-insurance? _________________________ Group name ____________________

Responsible Party (if patient is a minor)

Person responsible for this account____________________________________

Relationship to patient_______________ Address____________________________________

City_________________________ State_________ Zip___________ Home phone______________________________

Driver's license #____ Birthdate_________________________________

Social Security #____

Do you have additional insurance? __Yes __No **If yes, complete the following:**

Name of insured____ Relationship to patient_________________________

Birthdate_________________ Social Security #___________________________

Name of employer____ Work phone______________________

Insurance company______________________________ ID #___________________________ Group #_______________

Insurance co. address_________________________________ City___________________ State________ Zip_________

How much is your office visit co-pay/co-insurance? _________________________ Group name ____________________

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Patient Name: ____ Today's Date: ______________________

Drug Allergies: ϒ Yes ϒ No If yes, list drug allergies and how you reacted:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

List of current medications:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Surgical History

Have you had any of the following procedures? Please check all that apply.

□ Adenoidectomy □ Cosmetic Surgery □ Ear Surgery □ Neck Surgery □ Nose Surgery
□ Sinus Surgery □ Thyroid Surgery □ Vocal Cord Surgery □ Appendectomy □ Brain Surgery
□ Eye Surgery □ Gallbladder Surgery □ Heart Surgery □ Joint Replacement □ Organ Transplant
□ Pacemaker □ Skin Biopsy □ Spine Surgery □ Tonsillectomy

Comment(s):

____

Medical History

Have you had or do you currently have any of the following conditions? Please check all that apply.

□ Acid Reflux □ ADD/ADHD □ Anemia □ Anesthesia Complications □ Arthritis
□ Asthma □ Atrial Fibrillation □ Autoimmune Disease □ Bleeding Problem □ Diabetes
□ Cancer □ COPD □ Dementia □ Developmental Delay □ Heart Disease
□ Dizziness □ Ear Problems □ Headache □ Hearing Loss □ Liver Disease
□ High Blood Pressure □ High Cholesterol □ HIV/AIDS □ Kidney Disease □ Seizures
□ Nasal Fracture □ Nerve/Muscle Disease □ Nosebleeds □ Seasonal Allergies □ Stroke
□ Sickle Cell Disease □ Sinus Disease □ Sleep Apnea □ Sleeping Problem □ Voice Disorder
□ Thyroid Disease □ TMJ Problem □ Tuberculosis □ Speech Impairment

Comment(s):

____

Family History

Please check any of the following diseases/conditions that any of your blood relatives have been diagnosed with.

□ Asthma □ Cancer □ Clotting Disorder □ Diabetes □ Hearing Loss
□ Heart Disease □ High Blood Pressure □ Migraines □ Arthritis □ Rashes/Skin Problems
□ Seizures □ Sleep Apnea □ Stroke □ Thyroid Cancer □ Thyroid Disease
□ Unknown

Comment(s):

____

Social History

Tobacco Use

□ Current Every Day Smoker □ Current Some Day Smoker □ Never □ Former Smoker
□ Passive □ Heavy Smoker □ Light Smoker

Smokeless Tobacco Use

□ Current User □ Never Used □ Former User

Comments on your history with tobacco:

____

Alcohol Use: □ Yes □ No Drug Use: □ Yes □ No

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Carolina Sinus Center

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD WITHIN THE LAST 24 HOURS. CHECK ONLY THOSE THAT APPLY.

GENERAL/GENERAL

Appetite Loss/ Pérdida del Apetito
Chills/ Escalofrios
Fatigue/ Fatiga
Fever/ Fiebre
Night Sweats/ Sudores Nocturnos
Unintentional Weight Loss/Gain
Pérdida/Ganancia de Peso Involuntaria

SKIN /PIEL

Dryness /Sequedad
Excessive Sweating/Sudoracion Excesiva
Hair Loss/ Pérdida de Cabello
Hives/Ronchas
Itching /Picazón
New Lesions/changes/Nuevas Lesiones o Cambios
Rash/Erupción

NECK / CUELLO

Neck Pain or Stiffness/Dolor de Cuello o Rigidez
Neck Swelling / Hinchazón del Cuello
Neck Mass or Lump/Masa o Bola en el Cuello
Swollen Glands/Inflamación de los Ganglios

RESPIRATORY RESPIRATORIO

Cough /Tos
Difficulty Breathing/Dificultad para Respirar
Sputum Production/Flemas (Gargajos) Constantes
Asthma /Asma
COPD(Chronic Obstructive Pulmonary Disease)
Enfermedad Pulmonar Obstructiva Crónica

HEENT/HEENT

Throat Itching / Picor de Garganta
Ear Itch /Picor de Oído
Burning Mouth /Ardor en la Boca
Lump in Throat /Nudo en la Garganta
Headache /Dolor de Cabeza
Blurred Vision/ Visión Borrosa
Excessive Tearing /Lagrimeo Excesivo
Choking Sensation /Sensación de Ahogo
Eye Pain/Puffiness/ Dolor/Hinchazón en los Ojos
Visual Disturbances/ Alteraciones Visuales
Hearing Loss /Perdida de la Audicion
Ear Discharge/ Secreción del Oído
Ear Infection /Infección del Oído
Ear Pain /Dolor del Oído
Ringing in Ears/ Zumbido en los Oídos
Runny Nose /Nariz que Moquea
Spinning Sensation/Dizziness /
Sensación de Girar o Mareos
Nosebleeds /Hemorragias Nasales
Frequent Colds /Resfriados (Gripes) Frecuentes
Nasal Congestion /Congestión Nasal
Sneezing/ Estornudos
Seasonal Allergies/Alergias Estacionales
Sinus Pain /Dolor en las Sinositis
Snoring /Ronquidos
Hoarseness /Ronquera
Oral ulcers /Ulceras Orales
Sore Throat /Dolor de Garganta
Voice Changes/ Cambios en la Voz
Dry Mucous Membranes /Sequedad de las Mucosas
Decreased Sense of Smell / Disminución del Sentido del Olfato
Facial Numbness/Tingling / Entumecimiento/Hormigueo Facial

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GASTROINTESTINAL /GASTROINTESTINAL

Change in Bowel Habits/ Cambios en los Hábitos Intestinales
Difficulty or Painful Swallowing/Dificultad o Dolor al Tragar
Nausea or Vomiting/Náuseas o Vómitos
Reflux / Reflujo

CARDIOVASCULAR/CARDIOVASCULAR

Abnormal Bleeding /Sangrado Anormal
Cardiovascular Surgery /Cirugía Cardiovascular
Swelling of extremities/ Hinchazón de las Extremidades
Heart Disease/Enfermedad del Corazón
Fainting/Blacking Out/Desmayo/Perder el Conocimiento
Difficulty Breathing when Lying Down
Dificultad para Respirar al Acostarse

MUSCULOSKELETAL/MUSCULOESQUELÉTICO

Arthritis /Artritis
Joint Pain or Stiffness /Dolor en las Articulaciones o Rigidez
Physical Disability/Discapacidad Física

PSYCHIATRIC/ PSIQUIÁTRICO

Anxiety /Ansiedad
Change in Sleep Pattern /Cambios en el Patrón de Sueño
Personality Changes Cambios de Personalidad

ENDORINE/ENDOCRINO

Thyroid Problems /Problemas de la Tiroides
Diabetes/Diabetes

NEUROLOGICAL/NEUROLÓGICO

Attention Deficit/ Déficit de Atención
Difficulty Speaking /Dificultad para Hablar
Seizures /Convulsiones
Stroke/ Derrame Cerebral
General Weakness/Debilidad General

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Permission to Communicate (speak with listed individuals about your health and financial status)

In signing this authorization to release my protected health information I acknowledge that I have read and understand my rights to medical information confidentiality and authorize ENTAAC/CSC to discuss my health issues. I also authorize ENTAAC/CSC to discuss any financial information regarding my account with the following listed individuals only:

____

Name /Relationship

____

Name / Relationship

____

Patient Signature Date

Consent for Treatment of Minor (who is allowed to accompany patient under the age of 18) If the patient is a minor, please use the lines below to document all those that can accompany the patient/minor to the appointment and have access to personal medical records.

____

Name /Relationship

____

Name / Relationship

____

Patient Signature Date Date

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Patient Name____DOB__________________Date__________

Authorization to Share Medical and Financial Information HIPAA and Financial Agreement

Your Right to Medical Information Confidentiality, HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to Health & Wellness Clinic. In order to release any information including the date or nature of your visit, ENTAAC/CSC has to have your signed consent and specific directions about what information you are consenting to be released. Without written consent, ENTAAC/CSC cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coach and other medical professionals. In addition, you have the right to revoke this authorization at any time and will be effective when ENTAAC/CSC receives your written revocation. A copy of this authorization will be kept in your ENTAAC/CSC health record. The information disclosed under this authorization might be redisclosed by a recipient and may, as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in the possession of ENTAAC/CSC.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any patient balance as per my insurance.

The ensure timely settlement of accounts, patients are asked to leave a credit or debit card on file and authorize ENTAAC/CSC to process a charge up to $200.00, for any balance remaining after insurance has processed their claim. ENTAAC/CSC will contact you for approval for any balance greater than $200.00.

I am required to pay my estimated copay, deductible, and coinsurance at the time of service. A service charge of $10.00 will be applied to your account for any co-payment not received at the date of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I authorize the provider to release any information necessary to adjudicate the claim to my insurance carrier. I also understand that should my insurance company send payment to me; I will forward the payment to ENTAAC/CSC within 48 hours. I agree that if I fail to send the payment to ENTAAC/CSC and they are forced to proceed with collections process, I will be responsible for any cost incurred by the office.

BILLING AND COLLECTIONS

You should receive a statement approximately every thirty (30) days unless the charges are pending with your insurance company, or your balance is less than $5.00. If payment or denial is not received by your insurance company within ninety (90) days from claim submission, the total amount due will be your responsibility.

Any amount due remaining after your insurance has paid, denied, or not responding, is expected to be paid in full (by you) withing thirty (30) days unless other financial arrangements have been made with our billing office. Our formal collection process will begin after that time.

SELF-PAY

If you do not have insurance or are having a procedure that is not covered by your insurance, payment in full is expected on or before the date of service.

Authorization & Release for Insurance Payment

With this signature, I hereby authorize ENTAAC/CSC to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Furthermore, I understand that regardless of insurance, I am ultimately responsible for payment of fees for professional services rendered, including non-covered services. If my insurance company (ies) changes at any time, I am responsible to notify this office and provide a written copy or will be ultimately responsible for payment of professional service fees rendered at that time.

Collection Charges

In the event that any bill goes to a collection agency you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 28% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

RESPONSIBLE PARTY FOR MINORS (18 YEARS AND UNDER)

We assign all financial responsibility to the parent or guardian that completes and signs the patient registration form. Any amounts due at the time of service are expected from the parent or guardian accompanying the minor to the visit. In the event that a divorce decree assigns financial responsibility for medical bills to another individual, we still hold the registering parent or guardian responsible. We will however assist you in the recovering such payment by providing you with receipts showing that payment was made.

SURGICAL SERVICES AND PROCEDURES

Surgical Services are not covered at 100% by most insurance plans. Once benefits have been applied, patients are frequently responsible for a deductible, coinsurance and/or co-payment. It is therefore required that prior to surgery, financial arrangements be made to cover the balance due after the insurance company pays its portion. The following plan has been made available for your convenience.

CARECREDIT

CareCredit is a program that offers a line of credit with no interest or low interest payment options. It is "specifically designed for healthcare expenses and makes it easier for you to get the treatment or procedures you want and need. CareCredit is ideal for co-payments, deductibles, treatment and procedures not covered by insurance (CareCredit, Inc.,2005). " Please visit CareCredit's website for details at https://carecredit.com/patients/whatis.htm. Restrictions may apply.

My Signature Below Verifies:

I understand and agree that services rendered to me by ENTAAC/CSC are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to ENTAAC/CSC and I understand that I will be fully responsible for any outstanding balance on my account.

I understand my financial responsibility, I agree to authorization to share medical and financial information (HIPAA) for payment from insurance and for continuity of care for providers.

I authorize ENTAAC/CSC, their physicians, employees, or agents to perform a physical examination and/or any medical treatment deemed necessary by the treating physician. This includes, but is not limited to any medical examination, procedure, test ordered, and RX history performed or obtained by the physician to be carried out by the designated staff.

____ ____

Signature of Patient/Guarantor Date Printed Name Patient DOB

OR

____ ____

Signature of Parent/Guardian Date Printed Name Patient DOB