

# ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

Salutation/Titular: 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 2<sup>nd</sup> 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 also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Ear, Nose and Throat Associates Peter B. McKernan, M.D., D.D.S.

6101 Webb Road, Suite 211, Tampa, FL 33615 Phone: (813) 884-4967 Fax: (813) 889-0847 ENT-ASSOCIATES.COM

# ENT and Allergy Associates of Florida

Caring For Our Patients Since 1963

[ENT-ASSOCIATES.COM](http://ENT-ASSOCIATES.COM)

## MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M or F \_\_\_\_\_

Referring Physician: \_\_\_\_\_ \*Pharmacy Name \_\_\_\_\_

\*Pharmacy Cross Street/Phone Number \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Briefly, why are you seeing our physician today? \_\_\_\_\_

### 1. Patient History - Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	( )	( )	Nasal: Allergies	( )	( )
Heart (enter details below)	( )	( )	Nasal: Nasal Trauma	( )	( )
Cardio: Hypertension	( )	( )	Nasal: Nose Bleeds	( )	( )
Ear: Dizziness	( )	( )	Nasal: Sinusitis	( )	( )
Ear: Hearing Loss	( )	( )	Neuro: Headaches/Migraines	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )	Neuro: Nervous System	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	Oral: Sleep Apnea	( )	( )

	Yes	No		Yes	No
<b>G.I.:</b> Liver Disorders	( )	( )	<b>Psychiatric Disorders</b>	( )	( )
Stomach Disorders/Ulcer	( )	( )	<b>Pulmonary:</b> Lungs	( )	( )
Reflux/GERD/Heartburn	( )	( )	Tuberculosis	( )	( )
<b>Immuno:</b> HIV	( )	( )	<b>Urology:</b> Bladder	( )	( )
Immune Disease	( )	( )	Kidneys	( )	( )
<b>Lymph:</b> Anemia	( )	( )		( )	( )
Bleeding Disorders	( )	( )		( )	( )

Other: \_\_\_\_\_

**Details of Yes answers:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 2. Surgeries - Please list any surgeries/hospitalizations:

\_\_\_\_\_  
 \_\_\_\_\_

3. **Social History** - Are you a current smoker? ( Y or N ) You now smoke \_\_\_\_\_ packs of cigarettes a day.

4. You smoked \_\_\_\_\_ packs per day and quit \_\_\_\_\_ years ago.

5. You consume \_\_\_\_\_ alcoholic beverages per day / week / month (circle).

6. How many caffeinated beverages (8ounces) do you drink per day? \_\_\_\_\_

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

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

**Details of Yes answers:** \_\_\_\_\_

**Occupation (if retired, previous occupation):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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\_\_\_\_\_  
**(Print Patient Name)**

**Financial Consent**

**D.O.B:** \_\_\_\_\_

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 ENT and Allergy Associates of Florida, P.A. 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, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3<sup>rd</sup> party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

**Privacy Consent**

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

**Consent for Treatment**

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician's judgment.

**Message Consent**

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response:**  **Yes**  **No**



\_\_\_\_\_  
(Print Patient Name)

D.O.B: \_\_\_\_\_

**PBM Consent**

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

**Appointment Reminders**

ENT and Allergy Associates of Florida, P.A. uses a third-party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

**Consent Forms Acknowledgement**

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

**Patient/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medicare Consent (applies to Medicare beneficiaries ONLY)**

I certify that the information given by me in applying for payment under Title XVIII 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/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## **Patient No-Show & Cancellation Policy**

*Effective Immediately per ENT & Allergy Associates of Florida*

If you find that you are unable to make the appointment, ***it is necessary for you to notify us by phone at least 24-hours in advance of your appointment date and time.***

There will be a **\$100.00** fee charged directly to the patient/guarantor, NOT the patient's insurance, for those who either do not show up for their appointment or cancel with less than a 24-hour notice. For Services such as VNG and Audiology testing, the fee is **\$200.00.** Cancellation fees must be paid prior to the next appointment in order to be seen.

In the event an unforeseen circumstance requires an appointment to be cancelled without 24 -hours' notice, the fee will be waived, provided the appointment is rescheduled within one (1) business day.

Patient Name & DOB (Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_