ENT Specialists, Inc.

Current Health History Form

(To help your doctor better treat you, please complete all items as completely as possible)

Name: **Date of Birth:** **Age:** **Height:** _____ **Weight:** _____

1. What is the reason for your visit today: _____

_____

2. How long have you had this problem: _____

3. Who is your Primary Care Doctor: _____

Past Medical History

Y	N		Y	N		Y	N	
¡	¡	Heart Disease / Attack	¡	¡	Seasonal Allergies	¡	¡	Seizures
¡	¡	High Blood Pressure	¡	¡	Migraine Headaches	¡	¡	Mental Illness / Depression
¡	¡	Diabetes	¡	¡	Arthritis	¡	¡	Life threatening anesthesia reaction
¡	¡	Stroke	¡	¡	Bleeding Problems	¡	¡	Asthma
¡	¡	Emphysema / Bronchitis	¡	¡	Thyroid Disease	¡	¡	Acid reflux (GERD)
¡	¡	Sleep apnea	¡	¡	High Cholesterol	¡	¡	Cancer (specify location / treatment)
¡	¡	Sinus disease	¡	¡	Glaucoma			

Past Surgical / Hospitalization History (List any operations and all hospitalizations):

1. _____ **Date:** _____ **4.** _____ **Date:** _____

2. _____ **Date:** _____ **5.** _____ **Date:** _____

3. _____ **Date:** _____ **6.** _____ **Date:** _____

Medications **(Include over-the-counter non-prescription medications, vitamins, herbal supplements):**

_____ _____ _____

_____ _____ _____

Allergies to Medications? List below or check this box: ¡ No known medication / drug allergies.
Medication: _____ **Reaction: ¡ Rash ¡ Hives ¡ Anaphylaxis ¡ GI symptoms ¡ Other:**

Medication: _____ **Reaction: ¡ Rash ¡ Hives ¡ Anaphylaxis ¡ GI symptoms ¡ Other:**
*** Latex Allergy? ¡ No ¡ Yes**
Social History **Occupation:** _____ **Marital Status:** _____

Do you smoke? ¡ Never ¡ Not currently. I quit ____ years ago. ¡ I used to smoke ___ cigarette packs/day.

¡ Yes, daily. ___ cigarette packs/day for ___ years. or ¡ Yes, but not every day, for ___ years.

¡ Yes, I use: ¡ Pipe ¡ Chewing Tobacco

Alcohol consumption: ___ drinks/day or ___ drinks/week. Coffee: ___ cups/day ¡ caffeinated ¡ decaf

Review of Systems: Do you currently have any of the following? Check one box for each item.

Y	N		Y	N		Y	N	
¡	¡	Chest pain / angina	¡	¡	Heartburn	¡	¡	Memory loss
¡	¡	Heart murmur	¡	¡	Diarrhea or Constipation	¡	¡	Migraine headaches
¡	¡	Swelling of legs / ankles	¡	¡	Blood in the stool	¡	¡	Mood disorder
¡	¡	Shortness of breath	¡	¡	Liver failure	¡	¡	Visual loss
¡	¡	Chronic cough	¡	¡	Easy bruising / bleeding	¡	¡	Skin condition
¡	¡	Coughing or spitting up blood	¡	¡	Kidney failure	¡	¡	Weight loss: ___lbs in ___ months
¡	¡	Thyroid problem	¡	¡	Urinary tract infections	¡	¡	Weight gain: ___lbs in ___ months

What is your family history: (Blood relatives only) Check one box for each item.

Y	N		Y	N		Y	N	
¡	¡	Throat cancer or voice box cancer	¡	¡	Bleeding disorder	¡	¡	Migraine headaches
¡	¡	Thyroid cancer	¡	¡	Alcoholism	¡	¡	Allergic reaction to anesthesia
¡	¡	Hearing aid use as a child	¡	¡	Hay fever / allergies	¡	¡	Cancer, specify: _____
¡	¡	Hearing loss in adulthood	¡	¡	Heart disease or stroke	¡	¡	Other, specify: _____

Patient Signature: _____ **Date:** _____

Physician Reviewer: _____ **Date:** _____

ENT Specialists, Inc.

ENT Specialists Consent Form

Name:
Date of Birth:

Financial Policy

I have reviewed the **Patient Financial Policy** provided to me by ENT Specialists and hereby agree to the terms outlined in the **Patient Financial Policy**.

_____

Signature of Patient or Legal Guardian Date

COVID Consent to Treat

I have reviewed the **COVID Consent to Treat** form and I accept the risk and consent to treatment.

_____

Signature of Patient or Legal Guardian Date

HIPPA Authorization Form

I authorize ENT to speak with the following people concerning my care.

_____

_____

We may get an updated list of your medications as needed: YES or NO.

I authorize ENT to communicate with me through the following methods.

Cell phone: YES or NO Number: _____ Leave Message: YES or NO

Email: YES or NO Email Address: _____

(Office appointment confirmation calls will still be made)

Race: Native American Asian Black/African American White Hispanic Native Hawaiian

Ethnicity: Hispanic/ Latino YES or NO Primary Language: _____

I request the following restrictions to the use and disclosure of Health Information:

_____

I have reviewed the **HIPPA Authorization Form** provide to me by ENT Specialists and hereby agree to the terms and conditions outlined in the **HIPPA Authorization Form**.

_____

Signature of Patient or Legal Guardian Date

ENT Specialists, Inc.

Specialists, Inc.

Name:

Date of Birth:

COVID Health Questionnaire ENT Specialists

- ***(Please fill out within 24 hours of the visit)***

Do you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with have any of the following symptoms.

Fever: YES or NO

Chills: YES or NO

Cough: YES or No

Sore throat: YES or No

New loss of smell or taste: YES or NO

Trouble Breathing: YES or NO

Travel outside Massachusetts in the last 14 days

_____

COVID testing: YES or NO

If yes then: Date_____

Location_____

Results_____

Have you or anyone you have been in contact with been diagnosed with COVID or is in quarantine due to an exposure?

Date of your exposure to the person _____

I understand that if I answered yes to any of the questions, I may be asked to reschedule my appointment to a later date.

_____

Signature of patient or Legal Guardian Date

ENT Specialists Patient Information

HIPPA Authorization Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected. The rule was also created to provide a standard for health care providers to obtain their patients' consent for use and disclosure of health information to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information to provide care that is in your best interests.

We support your full access to your personal medical records. We may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you consent, then at some future time you may refuse part or all your PHI. You may not revoke actions that have already been taken which relied on a previously or currently signed consent.

If you have any objections, please ask to speak with our HIPPA compliance offices. You have the right to review our Privacy Notice and revoke consent in writing after you have reviewed our privacy notice.

Patient Financial Policy

I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what referrals, copayments and deductibles are required.

I understand that is my responsibility to provide with ENT Specialists with accurate and up to date information about my insurance coverage at the time of my visit.

I understand that copayments and deductibles, required by my insurance company, are my responsibility. I understand that charges not covered by my insurance plan are my responsibility. This includes charges not covered by my insurance plan because I failed to provide the necessary information at the time of the visit that would have allowed for the proper adjudication of the insurance claim.

I understand that if I do not call at least 24 hours in advance of my appointment to cancel, I may be charged an administrative fee of $50.00. I understand that repeated missed appointments may result in the inability to make future appointments. Notification will be sent to my primary care physician in the event of dismissal from the practice.

I authorize my insurance pan to pay benefits directly to ENT Specialists Inc.

I authorize ENT Specialists to release pertinent medical information when requested by my insurance company to facilitate payment of a claim.

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to ENT Specialists for any services provide to me by that provider. I authorize any holder on medical information about me to release to the CMS and its agents any information needed to determine these benefits or other benefits payable for related services. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

If you have questions, please refer to the attached full Patient Financial Policy Form.

COVID Consent to Treat

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19 at any time or any place. Be assured that we have always followed state and federal regulations and use personal protective equipment and have disinfections protocols to limit transmissions of all disease in our office. "Social Distancing" nationwide has reduced transmission and although we have taken measures to provide for social distancing, due to the nature of the services we provide, it is not always possible to maintain social distancing between patients, doctors, and staff at ENT.

ENT Specialists, Inc.