ENT Specialists Consent Form

Name:

DOB:

ACCOUNT #:

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

HIPAA Authorization Form

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

_____

_____

PRISMA is a data collection system we utilize at ENT Specialists to access your medical information from hospitals, physician offices and pharmacies. You are automatically opted in to PRISMA through our EHR system. If you want to opt out, please let the front desk know when you check in for your visit.

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

Cell phone: YES or NO Home phone: YES or NO Leave Message: YES or NO

Email: YES or NO Email Address: _____

(Office appointment confirmation calls will still be made)

Using artificial intelligence during your office visit for documentation: YES or NO

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

_____

_____

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

_____

Signature of Patient or Legal Guardian Date

ENT Specialists Health History Form

NAME:
DOB:
Primary Care: Dr.

Reason for Visit: _____

_____

Height:_____ **Weight:**_____

Please Circle Any Pertinent Medical History

Heart disease	Acid Reflux	Seasonal Allergies	Sinus Disease
High Blood Pressure	Asthma	Glaucoma	Thyroid Disease
Diabetes	Arthritis	Sleep Apnea	Cancer _____
Emphysema/Bronchitis	Bleeding Issues	Reaction to Anesthesia	High Cholesterol

Past Surgical History: List any operations/hospitalization.

1. _____ 2. _____ 3. _____

Medication (over the counter and prescription medications)

_____ _____ _____ _____

_____ _____ _____ _____

Allergies to Medications (circle reactions that apply)

No Known Drug Allergies (NKDA) **Latex allergy: YES or NO**

Medication: _____	Rash	Hives	Anaphylaxis	GI upset	Other_____
Medication: _____	Rash	Hives	Anaphylaxis	GI upset	Other_____
Medication: _____	Rash	Hives	Anaphylaxis	GI upset	Other_____

Occupation: _____
Smoker: **Yes or No**
Current Smoker: Packs/day_____ Years smoked_____
Prior Smoker: Quit_____ Packs/day_____ Years smoked_____
Chewing Tobacco: **Yes or No**
Alcohol: Drinks per day_____ or per week_____
Coffee: Cups/day _____

Patient Signature: _____ **Date:** _____

Physician Reviewer: _____ **Date:** _____