

PATIENT INFORMATION INSURED PARTY If same as patient, write "SAME"

Name _____
Name _____
First MI Last First MI Last
Address _____
Address: _____
City _____ State _____ Zip _____ City _____
State _____ Zip _____
Home Ph # _____ Work or Cell # _____ Home Ph # _____ Work/Cell _____
DOB _____ SSN _____ DOB _____
SSN _____
Marital Status _____ () Male () Female Marital Status _____ () Male () Female
Occupation _____
Occupation _____
Employer _____
Employer _____

INSURANCE #1 _____ **INSURANCE #2** _____

Phone number for benefit info _____ Phone number for benefit info _____

REFERRING PHYSICIAN OR SOURCE PRIMARY CARE PHYSICIAN

Name _____ Name _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____
State _____ Zip _____
Phone # _____ Fax # _____ Phone # _____ Fax # _____

FOR MINOR PATIENTS ONLY

PERSON PRESENTING PATIENT FOR TREATMENT IF DIFFERENT FROM INSURED PARTY

Name _____ DOB: _____ SSN: _____
Address: _____ City _____ State _____
Phone _____

Custody and maintenance issues are not our responsibility to define or enforce. We expect payment from the individual signing below as the responsible party. I understand that ENT ASSOCIATES OF SOUTH ATLANTA, LLC may need to contact me to confirm an appointment or for other patient care issues. I give my permission for the doctor or other office personnel to contact me at my home, office, cell phone or other numbers designated above, and to leave a detailed message in the event that I am unavailable. INITIAL HERE _____

I have read and fully understand the Financial Policy of ENT ASSOCIATES OF SOUTH ATLANTA, LLC.

Signature: _____ **Date:** _____

Name: _____ **Birth date:** _____

ENT ASSOCIATES OF SOUTH ATLANTA, LLC

IF THIS FORM IS NOT ANSWERED COMPLETELY, YOUR VISIT COULD BE DELAYED. This information will be entered into our electronic medical records system to create your chart. The written copy will be shredded to protect your confidentiality.

Name: _____ Birth Date: ____/____/____ Today's Date
____/____/____

WHAT PROBLEM(S) DO YOU NEED TO BE SEEN FOR TODAY?

SOCIAL HISTORY:

Do you drink alcohol? YES NO amount _____
Do you smoke currently? YES NO how much _____ how long _____
Have you smoked previously? YES NO how much _____ how long _____
Do you use other tobacco products? YES NO what/how often

(Chew, cigar, pipe)

Have you used illicit drugs in the past? YES NO what

Do you currently use illicit drugs? YES NO
what _____

Medical problems, chronic illnesses - Do you or your family members have any of the following:

YOU FAMILY MEMBER WHO: Mother/Father/Sibling

Diabetes YES NO YES NO _____

High blood pressure YES NO YES NO _____

Seizure disorder YES NO YES NO _____

Strokes YES NO YES NO _____

Thyroid disease YES NO YES NO _____

Bleeding disorders YES NO YES NO _____

Heart disease YES NO YES NO _____

Heart murmur YES NO YES NO _____

LIST ANY SERIOUS ILLNESSES YOU HAVE OTHER THAN THOSE LISTED ABOVE

HAVE YOU EVER HAD SURGERY WITH ANESTHESIA (PUT TO SLEEP) ? YES NO
OPERATIONS: AT AGE? OPERATIONS: AT AGE?

Name: _____ Birth Date: ____/____/____ Today's Date
____/____/____

Name must be written on both pages

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

Allergic to the following _____

Medications: List all medications that you currently take including prescriptions, over the counter and herbal medications. Include those you take occasionally. Use back if needed.

Name of Drug for what problem	Dose	How often	Used
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

In the last 14 days, have you taken the following:

Aspirin (of any strength) YES NO Date of last dose _____

Ibuprofen, Advil, Aleve YES NO Date of last dose _____

Anti-inflammatory medication YES NO Date of last dose _____

Do you have any food allergies? YES NO _____

Do you have any environmental allergies such as dust, mold, pollen? YES NO

Please _____ list:

REVIEW OF SYSTEMS:

Please circle any symptoms you are currently experiencing or have recently had.

Constitutional: fever chills loss of appetite unexplained weight loss night sweats

Eyes: vision loss double vision loss of peripheral vision

Heart: chest pain palpitations heart murmur swelling in hands or feet passing out

Lungs: shortness of breath cough wheezing coughing phlegm or blood

Abdominal: pain indigestion heartburn blood in stool

Urination: frequent or involuntary pain on urination blood in urine

Neurological: headaches loss of coordination numbness or tingling paralysis

Endocrine: hair loss growth or texture change excessive thirst frequently cold or hot

Hematologic

or Lymphatic: easy bruising bleeding gums excessive bleeding after minor cuts anemia

MEN

Height: _____ Weight: _____ Neck size: _____

Reviewed & Accepted into Patient history: _____ Date: _____

ENT ASSOCIATES OF SOUTH ATLANTA, LLC

FINANCIAL POLICY

In order to accommodate the needs and request of our patients we have enrolled in numerous insurance programs. However, due to evolution and mergers in the insurance industry we are not a member of all insurance plans. Therefore, **it is the responsibility of the patient/insured to confirm the individual physician's participation with a particular insurance plan**, as well as to know if or when referrals are required.

Providing quality medical care for our patients is our primary concern; we are more than willing to provide that care within your insurance contract guidelines. It is your responsibility to know at each time of service what those guidelines are.

It is your responsibility, as the patient/insured, to be aware of the current terms of your insurance coverage.

By contract, all co-pays, must be paid at the time of your visit. If your yearly

deductible has not been met, a portion of this may be required at the time of your visit.

If you participate in an insurance plan that requires you to have a referral for your visit, you must coordinate getting that referral through your primary care physician prior to your appointment. You are responsible for making certain the referral is in our office prior to your visit. Patients without valid referrals will be rescheduled or will be responsible for payment at the time of service.

Unfortunately, if you do not inform us of your contract's special requirements such as referrals, pre-certification or participating facilities and we subsequently order services, such as lab work, x-rays, CT scans, ultrasounds, sleep studies, hospitalization, etc., that are not covered, the selected medical facility we will have no choice but to bill you directly for those charges. Payment for such charges will then be your responsibility.

SELF PAY PATIENTS

If you do not have insurance, or insurance we participate with, payment is expected at the time of service. For your convenience we accept, cash, check, Visa, MasterCard, Discover, or American Express.

BENEFIT ASSIGNMENT

I hereby assign benefits to be paid to ENT ASSOCIATES OF SOUTH ATLANTA, LLC for services rendered to me.

RELEASE OF MEDICAL RECORDS

In accordance with HIPAA regulations, I hereby authorize ENT ASSOCIATES OF SOUTH ATLANTA, LLC to release medical information necessary to my process my insurance claims, or to other physicians in the coordination of my medical care.

I understand that if coverage is not in effect at the time of service, I will be billed in full for the charges. I have read and understand the office policy stated above and agree to accept responsibility as described.

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This questionnaire refers to your chance of falling asleep, according to your usual way of life, for about the last week or two. Even if you have not done some of these things recently, try to estimate how they would have affected you during the last two weeks.

Use the following scale to choose the most appropriate number for each situation:

Scale: 0 = **No** chance of dozing 1 = **Slight** chance of dozing 2 = **Moderate** chance of dozing 3 = **High** chance of dozing

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e.- in a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Epworth Score

Scoring: 7 or less = You have a normal amount of sleepiness 8 to 9 = You have a average amount of sleepiness 10 to 15 = You may be excessively sleepy depending on the situation and you may want to seek medical attention 16 + up = You are excessively sleepy and should seek medical attention

Patient and/or insured Date

FAX COVER SHEET

DATE: _____

TO: Ms. Brandon – New Patient Coordinator

404-768-9350

FAX: 404-768-2530

FROM: _____

Patient Name

**PLEASE FOLLOW THESE INSTRUCTIONS
FOR RETURNING YOUR PRE-REGISTRATION INFORMATION**

1. Make a copy of your insurance card, **please enlarge if your copier has the capability.**
2. Fax the following forms to the number above
 - a. patient info sheet
 - b. medical history forms
 - c. signed financial policy

After your patient information is entered into our system, we will call to verify your insurance benefits.

You will receive a reminder phone call the day before your appointment. At that time, we will inform you of any pertinent information such as deductible amounts, copay, other fees expected at the time of service.

Thank you for pre-registering with our office. We hope this will speed the process of your visit in our office. We look forward to serving you.