Central Tennessee Ear, Nose & Throat

Advanced Diagnostic Imaging/PhyData Group

Patient Demographics

Patient Information

Date:_____ **Email:**_____

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth:_____ **Sex: M**____ **F**____ **Other**____ **Social Security:** _____

Street Address:_____ **Apt#**_____

City:_____ **State:** _____ **Zip:** _____

Home#_____ **Cell#**_____ **Work#** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Other

Race: ☐ White/Caucasian ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African ☐ Hawaiian/Other Islander ☐ Other race

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Preferred Language**: ☐ English ☐ Spanish ☐ Other_____

Employer: _____ ☐ Full/Part ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Person Responsible for payment on account

Last Name: _____ **First Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ **Phone#**_____ **Relationship to patient:**_____

In case of emergency contact

Name:_____ **Phone:**_____ **Relationship to patient:**_____

Insurance Information

Primary:_____ **Policy ID#**_____ **Group#**_____

Policy Holder Name:_____ **DOB:**_____ **Relationship to patient:**_____

Secondary:_____ **Policy ID#**_____ **Group#**_____

Policy Holder Name:_____ **DOB:**_____ **Relationship to patient:**_____

Pharmacy Information

Pharmacy: _____ **Location:**_____ **Phone:**_____

May we access your prescription history through your pharmacy? YES_____ NO_____ Please sign below.

Signature of Patient/Representative: _____ **Date:** _____

Patient Financial Responsibilities and Assignment of Benefits

I authorize Central Tennessee Ear Nose & Throat to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Central Tennessee Ear Nose & Throat for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am responsible to inform Central Tennessee Ear Nose & Throat for any insurance changes and or insurance coordination of benefits and will be held liable for any charges for claim denials. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. I understand that I may incur, and be responsible for, the payment of additional charges, which may include, but not limited to: Charge for returned checks, copying and distribution of patient medical records, form completion and missed appointments.

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.
If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for all debtor-related unpaid account balances.

I have read, understand and agree to the provisions of this patient financial responsibility:

Signature of Patient/Representative: _____ **Date:** _____

Consent to Treat

I authorize Central Tennessee Ear Nose & Throat and staff to provide medical services to me and authorize the disclosure of protected health information for payment, healthcare operations and treatment to include communication with my physicians, pharmacists and hospitals. I understand that I have the right to request Central Tennessee Ear Nose & Throat to restrict the use of my protected health information for treatment, payment and healthcare operations and that Central Tennessee Ear, Nose & Throat may refuse this request. I understand that unless Central Tennessee Ear, Nose & Throat has taken action in reliance of such consent that I may revoke this consent by giving written notice. I understand to protect the privacy of my identifiable personal health information; Central Tennessee Ear, Nose & Throat and its Affiliates, has established a Privacy Policy and guidelines for Privacy Practices with their office**.**

Signed:_____ **Date:**_____

May we leave appointment details, medication or other medical information regarding you on your voice mail? **YES**____**NO**____

Spouse? **Y**___**N**___ Other Family Member? **Y**___**N**___ If yes, list 3 people you give permission to have access to your medical information.

1._____ **2.** _____ **3.** _____

Do you authorize to receive text messages regarding appointment reminders? **YES**____**NO**____

Notice of Privacy Practice Acknowledgement

I have read, and understand that in accordance with HIPAA Regulations, a copy of Central Tennessee Ear, Nose & Throat Privacy Practice Policy has been made available to me.

Patient Name:_____ **Patient's Guardian Name:**_____

Signature:_____ **Date:**_____

Patient Name/DOB:_____ Today's Date:_____

Reason for today's visit:_____ Date symptoms began:_____

Is this visit related to an Auto Claim or Workman's Comp Claim? ☐ No ☐ Yes

Past Medical History (check all that apply): ☐ None

☐ ADHD	☐ Croup	☐ Heart Attack	☐ Ringing in Ears
☐ Allergy/Hayfever	☐ Decreased Hearing	☐ Hepatitis	☐ RSV
☐ Anemia	☐ Depression/Anxiety	☐ High Blood Pressure	☐ Sinusitis
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Sleep Apnea
☐ Asthma	☐ Difficulty Swallowing	☐ HIV	☐ Snoring
☐ Auto Immune Disorders	☐ Dizziness	☐ Hoarseness	☐ Sore Throat
☐ Bleeding Disorder	☐ Ear Infection	☐ Kidney Disease	☐ Strep
☐ Chronic Fatigue	☐ Fibromyalgia	☐ Nosebleeds	☐ Stroke
☐ Congestive Heart Failure	☐ GERD/Heartburn	☐ Pneumonia	☐ Thyroid Disease
☐ COPD	☐ Headaches/Migraines	☐ Pregnant	☐ Tuberculosis

☐ Cancer (Type)_____ _____ _____

☐ Other Medical Problem(s)_____

Past Surgeries (include approximate date) ☐ None

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL current medication and dosage (use back if more space is needed) ☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies:

☐ No known drug allergies ☐ Statins ☐ Erythromycin ☐ Penicillin ☐ ACE Inhibitors

☐ IV Contrast Dye or Iodine ☐ NSAIDs ☐ Tetracycline ☐ Sulfas ☐ Latex

☐ Other Drug_____ ☐ Non Drug Allergy_____

Social History:

Tobacco Exposure: ☐ No ☐ Yes ☐ Environmental ☐ Occupational: ☐ Parent ☐ Child

Tobacco Use: ☐ No ☐ Yes; Type_____ Per day _____ # years _____ ☐ Quit: Date_____

Alcohol: ☐ Never ☐ Daily_____ ☐ Occasionally_____ ☐ Seldom_____

Qty Qty Qty

Family History: ☐ Unknown ☐ N/A

☐ Stroke ☐ Hypertension ☐ Diabetes Type (I or II) ☐ High Cholesterol ☐ Heart Attack

☐ Cancer (Who and What Kind)_____

☐ Other Medical History_____