CENTRAL TENNESSEE EAR, NOSE & THROAT PLC

ADVANCED DIAGNOSTIC IMAGING/PHYDATA GROUP

Patient Demographics

Patient Information

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

Date of Birth: _____ Social Security Number: _____

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

Home#_____ Cell#_____ Work#_____

Primary Care Physician: _____ Referring Physician: _____

Gender: ☐Male ☐Female **Marital Status**: ☐ Single ☐Married ☐Separated ☐Widowed ☐Divorced ☐ Other

Race: ☐White American/Caucasian ☐American Indian/Alaska Native ☐Asian American ☐Black/African American
☐Native Hawaiian/Other Pacific Islander ☐Some Other Race_____ ☐Unreported/Refused to Report

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic White/ Latino ☐Unreported/Refused to Report

Preferred Language: ☐English ☐Spanish ☐Other_____ ☐Unreported/Refused to Report

Employment Status: (if minor, Parent Employment Status): ☐Employed Full/Part ☐ Unemployed ☐Retired ☐Student ☐Disabled

Employer Name: _____ **City/State:** _____

Responsible Party (Person responsible for statements / invoice balances

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other **Marital Status**: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

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

Date of Birth: _____ Social Security Number: _____

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

Home#_____ Cell#_____ Work#_____

Employer Name: _____ City/State: _____

Emergency/Next of Kin Contact Information

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Pharmacy Information

Pharmacy Name: _____ Phone: _____

Street Location: _____ City/State: _____

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

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ADVANCE DIAGNOSTIC IMAGING/PHYDATA GROUP

Patient Name/DOB:_____

Insurance Information

Primary Insurance: _____

Policy/ID #:_____ Group/Plan#: _____

Policy Holder Name:_____DOB: _____SSN: _____

Policy Holder Address: _____State: _____Zip _____

Phone: _____Relationship to patient: _____

Secondary Insurance:_____

Policy/ID #:_____ Group/Plan#: _____

Policy Holder Name:_____DOB: _____SSN: _____

Policy Holder Address: _____State: _____Zip _____

Phone: _____Relationship to patient: _____

Tertiary Insurance:_____

Policy/ID #:_____ Group/Plan#: _____

Policy Holder Name:_____DOB: _____SSN: _____

Policy Holder Address: _____State: _____Zip _____

Phone: _____Relationship to patient: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

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

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Patient Name/DOB:_____

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:** _____

Electronic and Non- Electronic Correspondence:

There may be times our staff may need to leave messages via voicemail to communicate with you about your account, medical referrals and appointments. Please indicate if you authorize this or would like to opt out.

Authorize ☐ Opt out ☐

We also offer secure electronic communications between you and our office via our Patient Portal. Secure messages that are password protected and require log in to access the Portal site. The communications are automatically encrypted and for those who want to participate please provide email below.

☐ **Yes**, I would like to participate and my email is:_____

☐ **No**, I do not wish to participate at this time.

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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	☐Pregnant
☐Allergy/Hayfever	☐Decreased Hearing	☐Hepatitis	☐Ringing in Ears
☐Anemia	☐Depression/Anxiety	☐High Blood Pressure	☐RSV
☐Arthritis	☐Diabetes	☐High Cholesterol	☐Sinusitis
☐Asthma	☐Difficulty Swallowing	☐HIV	☐Sleep Apnea
☐Auto Immune Disorders	☐Dizziness	☐Hoarseness	☐Snoring
☐Bleeding Disorder	☐Ear Infection	☐Hyper/Hypo Thyroidism	☐Sore Throat
☐Chronic Fatigue	☐Fibromyalgia	☐Kidney Disease	☐Strep
☐Congestive Heart Failure	☐GERD/Heartburn	☐Nosebleeds	☐Stroke
☐COPD	☐Headaches/Migraines	☐Pneumonia	☐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: ☐None

☐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: Parent and/or Child

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

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

☐ Cancer (Who and What Kind)_____

☐ Other Medical History_____

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Patient Name/DOB:_____

Notice of Privacy Practice Acknowledgement

I understand that 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. This information details the use and/or disclosure of information contained in my personal medical records kept for the purposes of payment, treatment, other healthcare operations and usage of E-prescribing. In accordance with HIPAA Regulations, a copy of this Privacy Policy has been made available to me while in the office today.

Central Tennessee Ear, Nose & Throat and Affiliates reserves the right to modify privacy practices.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized representative signature **Date**

Printed name if signed on behalf of the patient

Please list the name of any person(s) to whom you would like to authorize Central TN ENT to release medical information to.

Name **Relationship**

Name **Relationship**

Name **Relationship**

This form will be retained in your medical record.

Updated March 2017.