The Otorhinolaryngology Associates, P.C.

R. G. LOVE, M.D.

Please Print Date: _____

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

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

Driver's License#: _____ SS#: _____/_____/_____ Sex: M F

Date of Birth: _____ Place of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Religion: _____ E-Mail: _____

Marital Status (circle one): Single Married Divorced Widowed Child

Employed (circle one): Yes No Retired Disabled Student Child

Employer: _____ Occupation (or former occupation): _____

Spouse: _____ **GUARANTOR: Yes ☐ No ☐**

Date of Birth: _____ SS#: _____/_____/_____ Phone: _____

Spouse Employer: _____ Occupation (or former occup): _____

Next of Kin (other than spouse): _____ Relationship: _____

Kin's Home Phone: _____ Cell Phone: _____ Work Phone: _____

REFERRAL

Referring Physician: _____ Regular/Family Physician: _____

Pharmacy: _____ Pharmacy phone#: _____

How did you hear about us? Radio Newspaper Internet Friend Other: _____

CHIEF COMPLAINT **Describe the problems that you are having.**

_____

_____

_____

Circle any of the following problems that you currently have.

Hearing Problems..... Yes No

Ear infections..... Yes No

Sinus/infections/Sinus Drainage..... Yes No

Throat infections/Tonsil Problems..... Yes No

Voice Problems/Hoarseness..... Yes No

Dizziness/Balance Disturbance..... Yes No

Cough..... Yes No

Neck Mass..... Yes No

Facial Lesion..... Yes No

Snoring/Sleep Problems..... Yes No

Sneezing/Allergy Problems..... Yes No

Nose Bleeds..... Yes No

Swallowing Problems..... Yes No

Facial Paralysis..... Yes No

System Review

Please indicate if you have or ever had any of the following, if YES please write a brief explanation.

Bleeding Problems	Yes	No	
Anemia	Yes	No	
Cancer	Yes	No	
Strokes	Yes	No	
Blocked Arteries	Yes	No	
Heart Problems	Yes	No	
Chest Pain/Angina	Yes	No	
MI/Heart Attack	Yes	No	
Dizziness/Fainting Spells	Yes	No	
Lung Problems	Yes	No	
Asthma	Yes	No	
COPD/Emphysema	Yes	No	
Hoarseness	Yes	No	
Stomach Ulcers	Yes	No	
Gastritis	Yes	No	
Reflux	Yes	No	
Intestinal Polyps	Yes	No	
Hepatitis	Yes	No	
Hayfever	Yes	No	
Allergic to pollen, grass, animals	Yes	No	
Allergic to foods	Yes	No	
Other allergies	Yes	No	
Allergy tests	Yes	No	
Allergy shots	Yes	No	
Sinusitis	Yes	No	
Sinus Polyps	Yes	No	
Snoring	Yes	No	
Sleep disorders	Yes	No	
Sleep apnea	Yes	No	
Anesthesia complications	Yes	No	
Kidney/prostate/bladder disorders	Yes	No	
Dialysis	Yes	No	
Hypertension/High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Arthritis	Yes	No	
Glaucoma	Yes	No	
Cataracts	Yes	No	
Retinal detachment	Yes	No	
Hearing Loss	Yes	No	
Ringing in the ears	Yes	No	
Ear Infections	Yes	No	
Ear wax plugs	Yes	No	
Fatigue	Yes	No	
Thyroid disorders	Yes	No	
Recent weight gain or loss	Yes	No	
Seizures	Yes	No	
Depression	Yes	No	
Have you ever been diagnosed with or treated for HIV?	Yes	No	
Any possibility you are pregnant?	Yes	No	
Any other health problems	Yes	No	

CURRENT MEDICATIONS

List all medications you are currently taking.

Drug	Dosage	Frequency	Prescribing Doctor

Over the counter Pain Remedies and or Antihistamines

DRUG ALLERGIES

List all your drug allergies and the reactions you had.

Drug	Reaction

HOSPITALIZATIONS / SURGERIES

Month/Year	Illness, Operation or injury	Doctor	Hospital

OTHER HEALTHCARE PROVIDERS

Internist:_____
OB/GYN: _____
Pediatrician:_____
Allergist:_____
Cardiologist:_____
Chiropractor: _____
Dermatologist: _____
Endocrinologist: _____
Gastroenterologist:_____
Nephrologist: _____
Oncologist:_____

Ophthalmologist:_____
Orthopedist:_____
Physical Therapist: _____
Plastic/Cosmetic: _____
Podiatrist:_____
Psychiatrist:_____
Pulmonologist:_____
Radiation Oncologist:_____
Rheumatologist:_____
Speech Therapist: _____
Other: _____

CHILDHOOD ILLNESSES

Measles.....	Yes	No	Chicken Pox.....	Yes	No
Rubella.....	Yes	No	Rheumatic Fever.....	Yes	No
Mumps	Yes	No	Whooping Cough.....	Yes	No
Polio	Yes	No	Scarlet Fever	Yes	No

Problems at Birth/ Birth Defects: _____

Inherited/ Genetic: _____

Other: _____

FAMILY HISTORY

Father Living: Yes No Cause of death: _____ Age at death: _____

Mother Living: Yes No Cause of death: _____ Age at death: _____

Check those that apply.	Father	Mother	Siblings	Children	Other Relatives
Asthma	☐	☐	☐	☐	☐ _____
Allergy/ Sinus	☐	☐	☐	☐	☐ _____
High Blood Pressure	☐	☐	☐	☐	☐ _____
Strokes	☐	☐	☐	☐	☐ _____
Hearing Loss	☐	☐	☐	☐	☐ _____
Heart Disease	☐	☐	☐	☐	☐ _____
Cancer	☐	☐	☐	☐	☐ _____
Bleeding Disorders	☐	☐	☐	☐	☐ _____

LIFESTYLE

Tobacco Use: Nonsmoker Smoker Former Smoker Year Started: _____ Year Quit: _____

Cigarette Quantity: _____ packs per day

Cigar Quantity: _____ per day

Smokeless tobacco: Yes No

Any illicit / recreational / street drug use / abuse: Yes No Please Describe: _____

Alcohol Use: None

	Quantity	Frequency
Wine	_____	_____
Beer	_____	_____
Spirits	_____	_____

Noise Exposure: Are you frequently exposed to loud noises without hearing protection, or have you been exposed in the past? Yes No **If yes, please explain below:**

_____

_____

Chemical Exposure: Are you frequently exposed to chemical vapors, or have you been exposed to chemical vapors in the past? Yes No **If yes, please explain below:**

_____

_____

Hobbies (circle all that apply): Hunting Fishing Golf Sports Scuba Diving Sailing Gardening Flying

Other: _____

PARENTS **Please complete this information if patient is a MINOR and/or under Guarantor's insurance policy.**

FATHER'S INFORMATION **GUARANTOR: Yes ☐ No ☐**

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

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

Marital Status: Single Married Divorced Widowed Spouse's Name:_____

SS#:_____/_____/_____ Date of Birth:_____ Driver's License #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employed: Yes No Retired Disabled Student Employer: _____

Occupation (or former occupation): _____

MOTHER'S INFORMATION **GUARANTOR: Yes ☐ No ☐**

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

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

Marital Status: Single Married Divorced Widowed Spouse's Name:_____

SS#:_____/_____/_____ Date of Birth:_____ Driver's License #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employed: Yes No Retired Disabled Student Employer: _____

Occupation (or former occupation): _____

****If divorced or separated, who has legal custody or guardianship of the child?** _____

INSURANCE INFORMATION

Primary Insurance

Company:_____ Contract #: _____

Group #:_____ Eff. Date:_____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____/_____/_____

Relationship to patient: Self Spouse Parent Other:_____

Secondary Insurance

Company:_____ Contract #: _____

Group #:_____ Eff. Date:_____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____/_____/_____

Relationship to patient: Self Spouse Parent Other:_____

Tertiary Insurance

Company:_____ Contract #: _____

Group #:_____ Eff. Date:_____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____/_____/_____

Relationship to patient: Self Spouse Parent Other:_____

SELF PAY INFORMATION (if uninsured)

Responsible Party:

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

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

SS#:_____/_____/_____ Date of Birth:_____ Driver's License #:_____

Home Phone: _____ Cell Phone:_____

Employed: Yes No Retired Disabled Student Work Phone: _____

Employer: _____ Occupation (or former occupation): _____

NOTICE OF PRIVACY AND SECURITY
OFFICE POLICY, INSURANCE AUTHORIZATION,
ASSIGNMENT and ENDURING REQUEST FOR CONSENT TO TREATMENT

I_____, hereby authorize The Otorhinolaryngology Associates, P.C. to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered, and agree to pay 1.5 % interest per month on all unpaid balances. The undersigned accepts the fee charges as a lawful debt and promises to pay said fees as outlined above including the cost of collection, reasonable attorney fees, and court cost, if necessary; waiving now and forever the right to claim exemption under the constitution of the state of Alabama or any other state.

By signing this affirmation document, I acknowledge that I have presented myself, or my family member or minor child to this medical office for evaluation and treatment. I am requesting consultative and potential surgical services and medical treatment by the physician(s) and staff of this office. I am giving my consent to the provision of physician's services and incident services by the staff. I agree to notify the staff at any time if I am concerned about any aspect of treatment to be provided.

By signing this affirmation document, I acknowledge that I have read and agree to be bound by the terms and conditions which apply to my participation in medical services provided by physician(s) and staff of this office as outlined in detail in the NOTICE OF PRIVACY AND SECURITY OFFICE POLICY and ENDURING REQUEST FOR AND CONSENT TO TREATMENT policy review document, a copy of which has been made available to me.

As a courtesy to me, this abbreviated signature document is provided to condense a tremendous amount of paperwork to one single page. My signature will be considered as "on file" for this visit and for future services provided by this office and for the proposes of compliance with State and Federal Law related to Health Care Services, and "on file" as a consent to bill third parties and accept assignment of payment from third parties whether in part or in full. Such third parties may include but not be limited to Medicaid, Medicare and Blue Cross Blue Shield or other carriers for service.

Patient: _____ Date: _____

Parent or Guardian:_____ Date: _____