

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 | _____ |
| Ringling 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.

| <u>Drug</u> | <u>Dosage</u> | <u>Frequency</u> | <u>Prescribing Doctor</u> |
|-------------|---------------|------------------|---------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Over the counter Pain Remedies and or Antihistamines

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

DRUG ALLERGIES

List all your drug allergies and the reactions you had.

| <u>Drug</u> | <u>Reaction</u> |
|-------------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

HOSPITALIZATIONS / SURGERIES

| <u>Month/Year</u> | <u>Illness, Operation or injury</u> | <u>Doctor</u> | <u>Hospital</u> |
|-------------------|-------------------------------------|---------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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. | <u>Father</u> | <u>Mother</u> | <u>Siblings</u> | <u>Children</u> | <u>Other Relatives</u> |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Allergy/ Sinus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Strokes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |

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 | <u>Quantity</u> | <u>Frequency</u> |
| 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: _____