DATE: ________________________

PATIENT INFORMATION FORM
(PLEASE FILL OUT EVERY SINGLE LINE)

Primary Care Doc: _________________________________ Referring Doc: _________________________________

FIRST NAME: _____________________ MIDDLE INITIAL: _____ LAST NAME:__________________________________

AGE: _______ DOB: ___________ RACE: ________________ MARITAL STATUS: ___________ SEX ☐ Male ☐ Female

SOCIAL SECURITY # __________ - _________ - ___________ EMAIL: _______________________________________

MAILING ADDRESS: ____ APT: _______________________

CITY / STATE: ____ ZIP: ___________________

PHONE: HOME ______________________ WORK ________________________ CELL _________________________

EMPLOYER: __________________ LANGUAGE: ____________ ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ NO RESPONSE

PREFERRED PHARMACY NAME: __________________ PHONE: __________________ CITY: ______________________

EMERG CONTACT: _____________________________ PHONE: ______________________ RELATIONSHIP: __________

RESPONSIBLE PERSON INFORMATION

☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ GUARDIAN

NAME: _________________________________ DOB: ___________ SOCIAL SECURITY #: __________________

ADDRESS: ____ PHONE: _______________ EMPLOYER: ___________

PATIENT INSURANCE INFORMATION

INSURED PARTY: (NAME ON INSURANCE CARD) _____________________________________ DOB: _______________________

ID: _____________ GROUP #: _________ EMPLOYER: _____________________ RELATIONSHIP: ___________________

SECONDARY INSUR: _______________________________________ ID: _______________________________________

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED TO DR. RONALD IANNACONE, ATLANTIC ENT ASSOCIATES P.A.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Agreement shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on this form. I authorize my doctor and/or the service provider to initiate a compliant to the Insurance Commissioner for any reason on my behalf.

I understand and agree (that regardless of my insurance), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: ______________________________________ DATE: __________________________

NAME: ____ DOB: ________________ TODAYS DATE: __________________________

HEIGHT: ___________ WEIGHT: ___________

SOCIAL HISTORY: DO YOU ☐ SMOKE ☐ FORMER SMOKER ☐ DRINK ALCOHOL ☐ DRUGS

MEDICAL HISTORY: DO YOU (THE PATIENT) HAVE A HISTORY OF (CHECK ALL THAT APPLY):

☐ HIGH BLOOD PRESSURE ☐ LUNG DISEASE ☐ THYROID DISEASE ☐ BLOOD TRANSFUSION

☐ DIABETES ☐ KIDNEY DISEASE ☐ TUBERCULOSIS ☐ MALIGNANT HYPOTHERMIA

☐ HEART DISEASE ☐ LIVER DISEASE ☐ PSYCHIATRIC DISEASE ☐ CANCER / OTHER

EXPLAIN ALL THAT ARE CHECKED:

____

SURGICAL HISTORY: LIST PREVIOUS SURGICAL PROCEDURES AND DATE(S) PERFORMED:

____

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____

DRUG ALLERGIES – LIST ALL DRUG ALLERGY AND ITS ASSOCIATED REACTION:

____

FAMILY HISTORY: DOES ANY MEMBER OF YOUR IMMEDIATE FAMILY HAVE A HISTORY OF:

☐ CANCER ☐ HEARING LOSS ☐ BLEEDING ABNORMALITIES ☐ DIABETES

☐ HEART DISEASE ☐ PROBLEMS WITH ANESTHESIA OR HIGH FEVER WITH ANESTHESIA

EXPLAIN ALL CHECKED:

LIST ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER MEDICATIONS:

____

____

REVIEW OF SYSTEMS - *HAVE YOU HAD CHRONIC PROBLEMS WITH ANY OF THE FOLLOWING*:

General: ☐ fever ☐ chills ☐ weight loss ☐ night sweat ☐ bleeding ☐ bruising ☐ rashes ☐ arthritis

HEENT: ☐ ear infections ☐ hearing loss ☐ allergic rhinitis ☐ nasal congestion ☐ throat pain

☐ visual problems ☐ choking ☐ hoarseness

CV: ☐ chest pain ☐ shortness of breath ☐ irreg heart beats ☐ circulation problems

GI: ☐ nausea ☐ bloody stool ☐ swallowing difficulties ☐ vomiting ☐ constipation ☐ heart burn

GU: ☐ incontinence ☐ bladder infections ☐ blood in urine ☐ kidney stones

Neuro: ☐ seizures ☐ numbness ☐ psychiatric illness ☐ slurred speech ☐ paralysis

Resp: ☐ bronchitis ☐ pneumonia ☐ coughing up blood ☐ asthma ☐ coughing

ATLANTIC ENT ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND IDENTITY THEFT PROTECTION

___________________________________	___________________________________
PRINT Patients Name	***Patients Date of Birth***

I have been presented with a copy of Atlantic ENT Associates Notice of Privacy Policies, which details how my information may be used and declared and permitted under federal and state law. I understand the contents of the Notice and that my health information may be used for treatment, payment and health operations.

I understand that photographs, or other images may be recorded to document my care and my identity, and I consent to this. I understand that ***Atlantic ENT Associates*** will retain the ownership rights to these photographs or other images, but that I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Atlantic ENT Associate***'s*** policy. Images that identify me will be released and/or used outside the institution only upon written authorization from my legal representative or me.

With regards to communications with my family and friends, ***Atlantic ENT Associates***, will not discuss or release any of my health information to any of my family members or friends unless that family member is my legal representative or is named below.

Family Member/Friend Name and Relationship to patient:

___________________________ ___________________________

Name Relationship

___________________________ ___________________________

Name Relationship

___________________________ ___________________________

Name Relationship

___________________________ ___________________________

Name Relationship

If the patient is a minor child, ***Atlantic ENT Associates*** will disclose his/her health information only to the mother and/or father of the child.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party accepting assignment. Regulations pertaining to medical assignment of benefits apply.

___________________________________	____________________	____________________
Signature of Patient or Legal Representative	***Relationship to Patient***	***Date***

( ) Patient refused to sign acknowledgment:

___________________________________	___________________________________
Signature of Atlantic ENT Associates Representative	***Date***