NORTHSIDE HEARING & BALANCE CENTER

Date:_____

PATIENT INFORMATION

Name_____ Date of Birth _____ Age _____

Social Security # _____ Sex: □ M □ F Marital Status: □ M □ S □ D □ W

Race_____ Language_____

Current work status: □ Employed – Occupation: _____ □ Unemployed □ Disabled □ Full-time student

Address_____ Apt. #_____ City/State/Zip_____

Home Phone_____ Work Phone _____Cell Phone_____

Email Address_____

Referring Doctor_____ Doctor's Phone_____

Primary Care Physician_____ PCP Phone _____

Are you currently participating in a clinical trial?_____

ALTERNATE CONTACT IF PATIENT CANNOT BE REACHED

Name_____ Relationship _____ Phone _____

Address_____ Apt. #_____ City/State/Zip_____

Pharmacy Name _____ Phone _____

Pharmacy Address_____

*** Please notify the office if you change pharmacies. Prescriptions will be sent to the pharmacy on file.

(A) PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

Enter the name of person who is responsible for the primary insurance

Cardholder's Name _____ Cardholder's Date of Birth_____ Relationship to Insured _____

ID #_____ Group #_____

Specialist Co-Pay $_____ Referral Required: □ Yes or □ No

Please check: □ Group Policy or □ Individual Policy Have you had this policy for longer than 12 months? □ Yes or □ No

Employer's Name_____ Work Phone _____

(B) SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Address: _____ City/State/Zip:_____

Cardholder's Name _____ Cardholder's Date of Birth_____ Relationship to Insured _____

ID #_____ Group #_____ Co-Pay $_____ Referral: □ Yes or □ No

Please check: □ Group Policy or □ Individual Policy Have you had this policy for longer than 12 months? □ Yes or □ No

Employer's Name_____ Work Phone _____

NORTHSIDE HEARING & BALANCE CENTER

PLEASE READ THE FOLLOWING CAREFULLY. INITIAL EACH SECTION, THEN SIGN AND DATE AT THE END.

CONSENT FOR TREATMENT

_____ I hereby consent to and authorize the performance of examinations and treatment for the below named patient that in the judgment of Georgia Northside Ear, Nose, and Throat's medical staff may be considered necessary or advisable.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

_____ I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand and consent that this information can and will be used to conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have the right to review Georgia Northside Ear, Nose, and Throat's Notice of Privacy Practices prior to signing this consent.

With this consent, Georgia Northside Ear, Nose, and Throat's and its employees may, but not limited to, call my home or other alternate locations, leave a message on voice mail or in person, can send mail to my home or an alternate location, in reference to any items that assist the practice in carrying out any treatment, payment or healthcare operations.

I may revoke my consent in writing except if the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Georgia Northside Ear, Nose, and Throat may decline to provide treatment to me.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ I have received, read and understand Georgia Northside Ear, Nose, and Throat's Notice of Privacy Practices containing a more complete description of the uses & disclosures of my healthcare information. I understand that Georgia Northside Ear, Nose, and Throat reserves the right to revise its Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by requesting one in person at Georgia Northside Ear, Nose, and Throat 1360 Upper Hembree Rd, Ste 201B Roswell, GA 30076

ASSIGNMENT OF BENEFITS

_____ I hereby authorize and assign that insurance payments for services provided to me, be made directly to Georgia Northside Ear, Nose, and Throat, LLC

FINANCIAL AND PAYMENT POLICY SIGNATURE FORM

SIGNATURE FORM SHALL BE HELD AS RECORD OF ACCEPTANCE OF FINANCIAL AND PAYMENT POLICIES

_____ I have received and read a copy of Georgia Northside Ear, Nose, and Throat, LLC. *Financial and Payment Policy* (2 pages). I understand and agree to abide by the policies noted which may be relevant to my financial obligations for services received from Georgia Northside Ear, Nose and Throat, LLC and its employees. I am also aware of my responsibility to provide Georgia Northside Ear, Nose, and Throat, LLC. with accurate and current information, with regard to my insurance coverage, address, and telephone number.

Your signature below indicates that you understand and agree to the before mentioned policies.

_____
Patient Name

_____ _____
Signature of Patient or Legal Guardian Date

NORTHSIDE HEARING & BALANCE CENTER

Date of Visit: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Referred for Opinion & Consultation by (Physician's name): _____

Primary Care Physician (if different): _____

REASON FOR TODAY'S VISIT:

_____

_____

Approximate date of onset: _____

DRUG ALLERGIES
Please list any food or drug allergies and reaction to each: _____

_____

MEDICATIONS
Please list all medications you are currently taking, including dosage.

Name of Medication	Dosage and how many times a day

If there are additional medications, please list below. Please bring an updated medication list to each appointment.

Northside Hearing Center

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please put a check mark.

	Cancer (List Type)		Headache/Migraine
	Heart Disease (Include Heart Murmur, Bypass Surgery, Pacemaker, CHF, Stent, Heart Attack)		Anxiety/Depression
	Anemia		Noise exposure
	Asthma or COPD		Kidney Disease
	Thyroid or Goiter Problems		Hearing Loss
	GERD		Sleep Apnea/Snoring
	Diabetes		High Cholesterol
	Epilepsy/ Seizures/ Neurological Problems		Hypertension
	Hearing aid use		Hyperthyroidism
	Bowel/ Colon Disease or Problems		Vertigo
	Bleeding or Clotting Abnormalities		Otosclerosis
	Syndromes		

Have you received a recent MRI or CT Scan of the head? □ Yes □ No Chemotherapy? □ Yes □ No

Past Surgeries or Other Medical Conditions

Have you ever had complications from surgery or anesthesia? □ Yes □ No

If yes, please explain: _____

FAMILY HISTORY

Have any of your direct relatives or immediate family members been treated for the following conditions?

✓	Condition	Mother	Father	Sister	Brother	Family n/o	Cause of death/ age
	Hearing loss						
	Other (explain)						

SOCIAL HISTORY

Do you use or have you formerly used any of the following products? (Please circle your response.)

Alcohol	Yes	No		Type:	Quantity:
Non-prescribed drugs	Yes	No		Type:	Quantity:
Caffeine	Yes	No		Type:	Quantity:
Tobacco	Never	Current	Former Quit Date:	Type:	Quantity: Do others family members smoke:

Northside Hearing Center

Patient Name: _____ Date of Birth: _____

Are you currently experiencing any of the following symptoms? Please indicate YES or NO

Yes	No	Symptom		Yes	No	Symptom		Yes	No	Symptom
		CONSTITUTIONAL				GASTROINTESTINAL				NEUROLOGY
		Chills				Abdominal pain				Incoordination
		Fatigue				Difficulty swallowing				Severe depression
		Fever				Constipation				Memory impairment
		Night sweats				Diarrhea				Seizures
		Weight loss				Heartburn				Speech changes
		Change in appetite				Nausea				Tremors
						Vomiting				Visual changes
		HEENT								
		Vertigo				RESPIRATORY				DERMATOLOGIC
		Ear infections or drainage				Cough				Contact allergy
		Hearing loss				Wheezing				
		Dizziness				Snoring				ALLERGY
		Facial Pain				Shortness of breath				Hay fever
		Ear Pain				Frequent upper respiratory infections				Hives
		Tinnitus (Ringing in Ears)								Asthma
		Eye Pain				REPRODUCTIVE				Food allergies
		Headache				Pregnant				Environmental allergies
		Nasal congestion								
		Nasal drainage				CARDIOVASCULAR				VASCULAR
		Nose Bleed				Irregular Heartbeat/Palpitations				Leg pain with exercise
		Sinus problems				Chest Pain				Varicose veins
		Sore throat								
		Hoarseness				ENDOCRINE				HEMATOLOGIC
		Neck mass				Goiter				Easy Bleeding
		Mouth ulcers				Excessive Thirst				Easy Bruising
		Visual changes								

NORTHSIDE HEARING & BALANCE CENTER

1360 Upper Hembree Road, Suite 101 Roswell, GA 30076 - 770.751.7437

RECORD RELEASE FORM

FROM: OFFICE/HOSPITAL _____

ADDRESS: _____

PHONE AND FAX NUMBER: _____

DATES OF SERVICE FROM: _____ TO: _____

SPECIAL REQUESTS: □ EKG □ Radiology □ Labs □ Office Notes □ All Records

_____

_____

PATIENT: _____ DOB: _____

PATIENT'S SIGNATURE: _____

The patient that is listed above is a patient of our office, and will be visiting our office within the next few days. Please fax us a copy of the patient's most recent or last office visit notes, labs, ultrasounds, ct scans, procedures, surgeries, pathologies, etc. The provided information will be for the physician to review so that we can better serve the patient. Thank you in advance from the physicians and staff at Georgia Northside Ear, Nose and Throat, LLC.