ENT Associates, Inc.

A division of SOUNDHEALTH SERVICES

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ SS Number: _____ Marital Status: S M D W

Language: English, Bosnian, French, German, Mandarin, Spanish, Vietnamese, Italian, Decline

Race: African American, American Indian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial, Native American, Declined

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Declined

Home Number: _____ Work Number: _____ Mobile Number: _____

Preferred Phone Contact: Home, Mobile, Work OK to Receive Text Messages: Yes or No

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Local Pharmacy: _____ Phone Number: _____

Referring Physician: _____ Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber/Policy Number: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Relationship to Patient: _____

Billing Address (if different from above): _____

Home Number: _____ Mobile Number: _____

Secondary Insurance: _____ Subscriber/Policy Number: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Relationship to Patient: _____

Billing Address (if different from above): _____

Home Number: _____ Mobile Number: _____

FINANCIALLY RESPONSIBLE PARTY (Person Bringing Child In)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Relationship to Patient: _____

Billing Address (if different from above) _____

Home Number: _____ Mobile Number: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature: _____ **Date:** _____

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to $35 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.
- **REFERRALS –** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.
- **CO-PAYMENTS –** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
- **FMLA AND/OR WORKMAN COMP –** There is a $25.00 charge for completion of Workman Comp or FMLA forms.
- **SURGERY DEPOSITS –** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.
- **OUT OF NETWORK PLANS –** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS –** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS –** The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.
- **INSUFFICIENT FUND CHECKS –** A $25.00 fee will be charged to patient's account for checks returned due to non sufficient funds
- You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, an additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Revised 04/01/2018

ENT Associates, Inc. Account # _____

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Medical History Questionnaire

Patient Name _____ **Age** _____ **Date of Birth** _____ **Date** _____

Primary Care Physician _____ **Referring Physician** _____

Today's appointment with: ☐ **Dr. Druck** ☐ **Dr. Maack** ☐ **Dr. Dahm** ☐ **Dr. Park**
☐ **Dr. Lima** ☐ **Dr. Marino** ☐ **Lisa Mantia** ☐ **Kristen Wilber**

Nature of Visit:

____ First visit, A consultation was requested by Doctor _____ (Please list doctor's name)
____ First visit, Referred by _____
____ This is a follow-up visit

- **Chief Complaint** (Reason for today's visit) _____
- **History of Present Illness:** (Describe the signs/symptoms that you have, when they started, and how they have changed)

Location (Where is the problem?) _____
Quality: (Dull, Throbbing, Sharp) _____
Severity: (Mild, Moderate, Severe) _____
Timing: (Daily, With activity, At night) _____
Duration (How long does it last?) _____
Associated signs & symptoms _____
Modifying factors (What makes it better or worse?) _____

- **Had Pneumonia Vaccine** ___Yes ___ No, if Yes, date of last vaccine _____
- **Flu Vaccine** ___Yes ___ No, if Yes, date of last vaccine _____
- **Do you currently take ANY medications** ___Yes ___ No, if Yes, please list **Name**, **Dosage** and **Frequency**:

Name	Dose	Frequency	Name	Dose	Frequency

Drug Allergies No Yes if yes, please list name of Drug _____ Reaction: _____

Latex Allergy No Yes

- **Past Medical History** ***(Have you been diagnosed with any of the following? Please check all that apply):***

☐ Cancer Type _____
☐ High Cholesterol
☐ High Blood Pressure
☐ Heart Trouble
Specify _____
☐ Diabetes, ☐ Type 1 ☐ Type 2
☐ Thyroid disorder, ☐ Hypo ☐ Hyper
☐ STD
Specify _____
☐ Hepatitis, ☐ A ☐ B ☐ C
☐ Gastric Reflux

☐ Kidney Disease
Specify _____
☐ HIV
☐ Bleeding problems
Specify _____
☐ Autism
☐ Stroke / TIA
☐ ADD / ADHD
☐ Nervous / Psych disorder
Specify _____

☐ Asthma
☐ COPD
☐ Emphysema
☐ Sleep Apnea
☐ Tuberculosis
☐ Pneumonia
☐ Autoimmune disorder
Specify _____
☐ Genetic Disorder
Specify _____
☐ Allergy

☐ Other: _____

☐ **No Past Medical History**

- **Past Surgical History:**

☐ Appendix
☐ Gallbladder
☐ Breast Surgery
☐ Left ☐ Right
☐ Heart Surgery
Specify _____
☐ Hysterectomy

☐ Chemo or Radiation Therapy
☐ Transplant Surgery
Specify _____
☐ Ear Tubes, ☐ Left ☐ Right
☐ Ear Surgery
Specify _____

☐ Neck Surgery
Specify _____
☐ Sinus Surgery
Specify _____
☐ Nasal
☐ Adenoidectomy
☐ Tonsillectomy

☐ Surgery not listed above: _____

☐ **No Past Surgical History**

Please Continue On Back Side

Account # _____

- **Social History**

Occupation _____ **Marital Status** _____

Environmental Exposure: Dust_____ Fumes _____ Solvents _____ Noise _____

Smoking/Tobacco History

☐ Never

☐ Former Smoker # years smoked _____ # per day _____ Date Quit _____

Type: ☐ Cigarette ☐ Cigar ☐ E-Cigarette/Vape ☐ Snuff/Chew ☐ Other _____

☐ Current Smoker # per day _____ Date started _____ How long? _____

Type: ☐ Cigarette ☐ Cigar ☐ E-Cigarette/Vape ☐ Snuff/Chew ☐ Other _____

Do you drink Alcohol?

☐ Never
☐ Rarely
☐ No, I quit ____ years ago. I was drinking____ drinks per day / week / month (circle one) for____ years.
☐ Yes, I have ____ drinks per day / week / month (circle one). List type of alcohol:_____

- **Review of Current Symptoms:** ***(Check any of the following that apply to you.)***

Constitutional	Eyes	ENT	Cardiovascular	Respiratory	Gastrointestinal	GU
☐ Fever	☐ Vision change	☐ Hearing Loss	☐ Chest Pain	☐ Shortness of Breath	☐ Nausea	☐ Freq/urinate
☐ Weight Gain	☐ Glasses	☐ Vertigo	☐ Foot/Ankle Swelling	☐ Wheezing	☐ Vomiting	☐ Pain/urinate
☐ Night Sweats	☐ Contacts	☐ Sore throat		☐ Snoring	☐ Diarrhea	☐ Blood in urine
☐ Fatigue		☐ Hoarseness		☐ Sleep Apnea	☐ Heart Burn	
		☐ Nose Bleeds			☐ Ulcers	

Musculoskeletal	Skin	Neurology	Psychiatry	Endocrine	Hematology	Allergy
☐ Foot Pain	☐ Rash	☐ Numbness	☐ Confusion	☐ Heat	☐ Swell/lymph	☐ Sneezing
☐ Muscle Weakness		☐ Headache	☐ Anxiety	☐ Cold	☐ Blood Transfusion	☐ Itching
☐ Joint Pain		☐ Slurring	☐ Depression			☐ Food
		☐ Seizures				☐ Congestion

- **Family Medical History:** ***(Do any family members have any of the medical problems listed below?) Check all that apply***

Example: Mother = M, Father = F, Grandmother = GM, Grandfather = GF, Brother = B, Sister = S, Aunt = A, Uncle = U

	Relationship		Relationship
☐ Heart Trouble	_____	☐ High Blood Pressure	_____
☐ Diabetes	_____	☐ Cancer	_____
☐ Kidney	_____	☐ Asthma	_____
☐ Liver Disease	_____	☐ Stroke or TIA	_____
☐ Bleeding Tendencies	_____	☐ Nervous / Psychiatric Disorder	_____
Specify _____		Specify _____	
☐ Gastric Reflux	_____		
☐ Hearing Loss	_____	☐ **Other** _____	

☐ **No Known Family History**

PLEASE SIGN:

Patient or Responsible Party Signature: _____

Vital Signs: Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

Physician Signature _____ **Date**_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth: _____

I understand that Sound Health Services, P.C. (the "Practice) has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers

_____ .

I authorize Sound to report any test results on any telephone answering device or service which may answer the telephone number I inserted in the preceding paragraph.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

_____

_____

_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.
Attn: Privacy Officer
3860 South Lindbergh
St. Louis, MO 63127

_____ _____

Signature of Patient/Patient's Representative Date:

Basis of representative's authority to act for patient:_____

_____

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AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR PATIENT

Under Missouri law, prior to providing medical treatment to a patient under the age of eighteen years old in a non-emergency situation, ENT Associates, Inc. must obtain consent from the minor's parent or legal guardian prior to treating the patient. If there is likely to be an occasion where your child will be brought to our office for treatment by an adult relative, babysitter, or other person over the age of eighteen years of age, as the parent or legal guardian, must first delegate such person with the authority to consent to your minor child's treatment on your behalf.

I,_____, of_____
(Name) (Address)

the parent or legal guardian of:

Name of Patient: _____ Date of Birth: _____

hereby delegate and authorize the following adult individuals, in my absence, to consent to the care of my minor child and to sign any necessary waivers on my behalf.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

During such periods of time such designated adults shall also have the authority to access and to consent to the use and disclosure of the minor child's protected health information.

THE UNDERSIGNED ACKNOWLEDGES AND AGREES TO PAY ALL COSTS AND EXPENSES INCURRED IN CONNECTION WITH ANY MEDICAL TREATMENT RENDERED BY ENT ASSOCIATES TO THE MINOR PATIENT FOLLOWING THE CONSENT OF ONE OF THE ADULTS DELEGATED ABOVE.

_____ _____
Parent/Legal Guardian Signature Date

_____
Parent/Legal Guardian Name

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL CHANGED OR REVOKED BY THE ABOVE PARENT OR LEGAL GUARDIAN.

Please complete the patient information section on the following page regarding your minor child's health information

POS Reorder # 1823048