WELLENDORF ENT PATIENT INFORMATION

Pharmacy of Choice: ________________________________ Location: ____

Patient Name: ____
Last First M.I.

Date of Birth: __________ / __________ /___________ Age: _______________ Sex: M F

Social Security Number: __________ - ____________-___________

Race: (Circle one) American Indian/Alaska Native Asian Black/African American White Other Declined

Ethnicity: (Circle one) Declined Hispanic or Latino Not Hispanic or Latino

Primary Language Spoken:____

Marital Status: S M D W Other Spouse's Name: ____________________________ DOB:__________

Mailing Address: ____
Street Address

____
City State Zip

Home Phone Number:________________________________ Cell Phone Number: _______________________________

Email Address:_____________________________________
(patient, if over 18, or responsible person, if patient under 18)

Preferred Way to be Contacted: (Circle one) Declined Mail Home Phone Cell Phone Email

Employer: ____ Work Phone Number:______________________________

Family Physician:___________________________________ Referring Physician: _____________________________

How did you hear about us: (Circle one) Radio TV Newspaper Friend Family Physician

Person Responsible for Bill: __________________________ Relationship to Patient:___________________________

Responsible Person Address: ____
Street Address City/State/Zip

Responsible Person DOB: _______ / _________/ __________ Social Security Number: _______ -_______-______

Phone Number: ____________________________________ Cell Phone Number: _______________________________

Employer: ____ Work Phone Number:______________________________

Other Responsible Person: _______________________________________ Relationship:_________________________

Other Responsible Person Address: ____
Street Address City/State/Zip

Responsible Person DOB: _______ / _________/ __________ Social Security Number: _______ -_______-______

Phone Number: ____________________________________ Cell Phone Number: _______________________________

Employer: ____ Work Phone Number:______________________________

Please Provide Your Insurance Information (We will also need to scan your insurance card and photo ID)

Primary Insurance: _________________________________ Name of Cardholder: ______________________________

Cardholder's DOB: _________________________________ Cardholder's SSN: _________________________________

Secondary Insurance: _______________________________ Name of Cardholder: ______________________________

Cardholder's DOB: _________________________________ Cardholder's SSN: _________________________________

I certify that the above information is true and correct to the best of my knowledge. I have been presented with Wellendorf ENT Financial Policy. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Patient or Authorized Person's Signature: _____________________________________**Date:**___________________

PLEASE COMPLETE BOTH SIDES

WELLENDORF ENT

NAME:____ **Age:** ____________ **DOB:** _______________

This form is to help give you better health care. It is completely confidential and will be part of our medical record. If you have any questions regarding your answers, please wait and ask the doctor.

REASON FOR TODAY'S VISIT: ____

What makes it better:_____________________________________ Worse:______________________________

PERSONAL MEDICAL HISTORY:

Condition	Self	Family	Condition	Self	Family
Allergies	Self ____	Family ____	HIV/AIDS	Self ____	Family ____
Anemia	Self ____	Family ____	Indigestion	Self ____	Family ____
Arthritis/Joint Pain	Self ____	Family ____	Irregular Heart	Self ____	Family ____
Asthma	Self ____	Family ____	Jaundice	Self ____	Family ____
Bleeding Disorder	Self ____	Family ____	Kidney Disease	Self ____	Family ____
Chest Pain	Self ____	Family ____	Night Sweats	Self ____	Family ____
Convulsion	Self ____	Family ____	Nosebleeds	Self ____	Family ____
COPD/Emphysema	Self ____	Family ____	Pacemaker	Self ____	Family ____
Cough	Self ____	Family ____	Shortness of Breath	Self ____	Family ____
Coughing Blood	Self ____	Family ____	Sinusitis	Self ____	Family ____
Diabetes	Self ____	Family ____	Skin Cancer	Self ____	Family ____
Difficulty Swallowing	Self ____	Family ____	Stroke	Self ____	Family ____
Dizziness	Self ____	Family ____	Thyroid Disease	Self ____	Family ____
Epilepsy	Self ____	Family ____	Tonsillitis	Self ____	Family ____
Glaucoma	Self ____	Family ____	Tuberculosis	Self ____	Family ____
Hearing Loss	Self ____	Family ____	Ulcer	Self ____	Family ____
Heart Disease	Self ____	Family ____	Vision Changes (other than glasses)	Self ____	Family ____
Hepatitis	Self ____	Family ____	Weight Loss	Self ____	Family ____
High Blood Pressure	Self ____	Family ____	Other	Self ____	Family ____

SURGICAL HISTORY:

____Appendix ____D&C ____Ear Surgery ____Gallbladder ____Heart Surgery ____Heart Stent

____Hysterectomy ____Joint Replacement ____Nasal Surgery ____Prostate ____Thyroidectomy ____Tonsils/Adenoids

____Other ____

____No Prior Surgery

Complications with anesthesia? ____

CURRENT MEDICATIONS:

Do you take aspirin daily? ___Yes ___No

List all the medications you are currently taking. Include over-the-counter, herbal and medications that you take only occasionally.

____

____

____

Medications prescribed for current complaint:____

Are you allergic to any medication? ___Yes ___No If yes, please list: ______________________________

____

PHYSYCOSOCIAL HISTORY: Pediactric only: Are immunizations up-to-date? ___Yes ___No

Do you consume alcohol? ___Yes ___No If yes, how much/often? ______________________________

Tobacco Use: ___Current ___Former ___Never If yes: ___Smoke ___Chewing Tobacco? ___Smoke Exposure?

Age Started: ______ Age Stopped: ______ How much and how often? ___________________________

Do you take recreational drugs (cocaine, marijuana, etc.)? _________________________________

Are you pregnant? ___Yes ___No

Height ___________Weight ____________

What kind of work do you do? ____

FAMILY HISTORY:

Do you know of any inherited diseases or bleeding disorders in your family? ______________________

PATIENT SIGNATURE:____ **DATE:** ________________

PLEASE COMPLETE BOTH SIDES

WELLENDORF ENT

REVIEW OF SYSTEMS:
Please put an “X” on the line to indicate whether you presently have any of the following symptoms.

GENERAL	Fatigue	____	Weight Gain	____	Daytime Sleepiness	____
	Fever	____	Chills	____	Weight Loss	____
EYES	Eye Pain	____	Watery/Itchy Eyes	____		
ENT	Change in Vision	____	Hoarseness	____	Difficulty Swallowing	____
	Ear Pain	____	Hearing Loss	____	Nasal Congestion	____
	Ringing/Sounds in Ears	____	Sinus Pain/Pressure	____	Sleep Apnea	____
	Snoring	____	Sore Throat	____		
CARDIAC	Chest Pain	____	Rapid Heart Rate	____	Irregular Heart Beat	____
	Leg Swelling	____				
RESPIRATORY	Shortness of Breath	____	Cough	____	Wheezing	____
	Coughing Blood	____				
GI	Heartburn	____	Difficulty Swallowing	____		
GU	Frequent Urination	____	Painful Urination	____		
SKIN	Rash	____	Pigmentation Changes	____	Hair Growth Changes	____
	Hives	____	Itching	____		
NEURO	Seizures	____	Headache	____	Passing Out	____
	Dizziness	____				
MSK	Joint Pain	____	Muscle Pain	____		
ENDO	Feel Cooler than Others	____	Feel Warmer than Others	____		
PSYCHE	Depression	____	Mental Health Problems	____		
HEME/LYMPH	Night Sweats	____	Bleeding Problems	____	Easy Bruising	____
	Swollen Glands	____				
ALLERGY	Sneezing	____	Throat Dryness/Itching	____	Environmental Allergy	____
	Post Nasal Drip	____				

Please list more details about your ears, nose and throat problems below:

____

____

____

HIPAA RELEASE FORM

Patient Name: ____

Date of Birth: ____

If we are unable to reach you, may we leave a message regarding test results, upcoming appointments, etc.? Yes / No

If yes, number to leave message:______________________________

With whom may we speak regarding your medical care (i.e. spouse, parents, grandparents, children)?

Name__________________________________ Phone ____________________

Name__________________________________ Phone ____________________

Signed______________________________________ **Date** ____________________

Notice to Patient: By signing below, I acknowledge that I have received a copy of Wellendorf ENT Privacy Practices.

____

Printed Name of Patient Date

____

Signature of Patient or Patient’s Representative

____

Printed Name of Patient’s Representative (if applicable) Relationship to Patient

Office Use Only:

Account# ______________________________

PLEASE COMPLETE BOTH SIDES

FINANCIAL POLICY

Thank you for choosing Wellendorf ENT for your Ear, Nose and Throat needs. We are dedicated to providing exceptional care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. As a courtesy to you, we will bill all medical claims with your primary and secondary insurance plans, based upon your authorization to release your plan's benefits to us. All claims are filed within standard HIPAA guidelines. Please review below and contact us if you have any additional questions.

Proof of Insurance: We ask that you bring your insurance card at the time of your visit. This is to ensure we have your most recent insurance information to accurately submit your claim.

Referrals & Authorizations: If your insurance requires a referral or an authorization, it must be in place prior to your appointment or you may be asked to reschedule your visit. It is ultimately the responsibility of the patient / parent / legal guardian to contact your primary care physician (PCP) to obtain a referral, if required. Please contact your insurance company if your plan requires prior authorization to be seen. If you are referred beyond Wellendorf ENT, it is also your responsibility to contact your insurance company to see if they contracted with your plan.

Co-Payment: If your insurance requires a co-payment, **it is due at the time of your visit**. You may be asked to reschedule your appointment if the co-payment cannot be collected at the time of service. Co-insurance and deductible payments will also be collected at the time of service, when known. We accept cash, checks and all major credit cards. There is a $30.00 service charge for returned checks.

Insurance: Your insurance policy is a contract between you and your insurance company. Wellendorf ENT is not involved. It is your responsibility to be aware of your insurance plan coverage, eligibility, deductibles, co-insurance and benefits provisions.

In-Office Procedure: In order for the physician to evaluate and/or treat your condition, he/she may need to do a procedure or use an instrument that your insurance classifies as a "surgical procedure." Some of these types of diagnostic procedures, such as fiberoptic laryngoscopy and endoscopy, may be classified this way and could be applied to your deductible or co-insurance as an out-of-pocket expense to you, if applicable. This amount is determined by our insurance plan benefits and varies between plans.

Additional Testing: Please note if you require radiology (such as a CT scan), or audiology services (such as a diagnostic hearing test), this is also billed to your insurance company but may require additional co-payments, referrals and could be applied to your deductible or co-insurance as an out-of-pocket expense to you.

Surgical Procedure: If you require a surgical procedure (non-office procedure), please note you will receive separate billing statements from the hospital, surgeon(s) and the anesthesia department. Pre-payment will be required on all surgical procedures. Payment plan option is available at www.carecredit.com on all surgical and office procedures.

Post-Surgical Visits: Office visits after surgery that are related to that surgery and are within the "global period" (specific number of days after surgery) are included in the surgical charge and will not require an additional co-payment or referral. If your visit with us falls outside the global period, standard billing practices apply.

Delinquent Account: If your account is over 90 days past due, you will receive two letters approximately twenty days apart stating your account is past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, our healthcare providers will only be able to treat you on an emergency basis.

Missed Appointments: We understand that occasionally a patient cannot make a scheduled appointment. We ask that you call our scheduling line (888-339-4368) to cancel your appointment at least 24 hours in advance.

I have read the financial policy from Wellendorf ENT and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

____________________________________ ____________________________________

Signature of Patient or Responsible Party if a Minor | Date | Please Print Name of Patient | Date of Birth

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INVITATION TO PATIENT PORTAL

We are required to ask everyone for an email address so you may access your patient portal.
If unable to provide this, please mark below.

Patient Name: ______________________________

Email Address: ______________________________

Unable to provide at this time ____________________

Signature: ______________________________

PLEASE COMPLETE BOTH SIDES