WELLENDORF ENT PATIENT INFORMATION

Patient Name: _____ Sex: M F
Last First M.I.

Date of Birth: _____ / _____ / _____ Age: _____ Social Security Number: _____-_____-_____

Mailing Address: _____
Street Address

_____
City State Zip

Home Phone Number:_____ Cell Phone Number: _____

Email Address:_____ Primary Language Spoken: _____
(patient, if over 18, or responsible person, if patient under 18)

Employer: _____ Work Phone Number:_____

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

Family Physician:_____ Referring Physician: _____

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

Pharmacy of Choice:_____ Location:_____

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

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

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: _____

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:** _____

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:

_____

_____

_____

_____

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:

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
Adult: Do you consume alcohol? ___Yes ___No If yes, how much/often? _____
Tobacco Use: ___Current ___Former ___Never If yes: ___Smoke ___Chewing Tobacco?
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:** _____

NOTICE OF PRIVACY POLICIES FOR WELLENDORF ENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At WELLENDORF ENT, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit WELLENDORF ENT, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. Understanding what is in your record and how your health information is used helps to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Federal law grants you certain right with respect to your Protected Information. Specifically you have the right to:

- ➔ Receive notice of our policies and procedures used to protect your Protected Information.
- ➔ Request that certain uses and disclosures of your Protected Information be restricted, provided however, we have the right to refuse your request.
- ➔ Access to your Protected Information, provided however, the request must be in writing and may be denied in certain limited situations.
- ➔ Request that your Protected Information be amended.
- ➔ Obtain an accounting of certain disclosures by us of your Protected Information for the past six years.
- ➔ Revoke in writing any prior authorization for use or disclosure of Protected Information, except to the extent that action has already been taken.
- ➔ Request communications of Protected Information are done by reasonable alternative means or at alternative locations.

Our Responsibilities

Federal law also imposes certain obligations and duties upon us with respect to your Protected Information. Specifically, WELLENDORF ENT is required to:

- ➔ Provide you with notice of our legal duties and our facility's policies regarding the use and disclosure of your Protected Information.
- ➔ Maintain the confidentiality of your Protected Information.
- ➔ Review your requested restrictions regarding the use and disclosure of your Protected Information and inform you if these restrictions will be used.
- ➔ Allow you to inspect and copy your Protected Information during our regular business hours with a scheduled appointment pursuant to any legal restrictions. Please contact our Privacy Officer for fess and/or an explanation of our fee structure for copies, staff time charges and postage.
- ➔ Act on your request to amend Protected Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension. Although this does not guarantee that amendment is appropriate.
- ➔ Accommodate reasonable requests to communicate Protected Information by alternative means or methods.
- ➔ Abide by the terms of this notice.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

How Your Protected Information May Be Used and Disclosed

Generally your Protected Information may be used and disclosed for treatment, payment or operations as required by law. This includes a variety of areas:

We will use your health information for treatment.

We may use or disclose your Protected Information for treatment purposes, including continuing care and case or care management. During your care at our office, it may be necessary for various personnel, including but not limited to, physicians, nurses, or other members of your health care team involved in your care to access to your Protected Information in order to provide you quality care.

We will also provide your physician and or a subsequent health care provider outside of our office with copies of various reports that should assist him or her in treating you with your current or future care.

We will use your health information for payment.

Your Protected Information may also be used or disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that treatment and services provided by us may be billed and collected from you, your insurance company or other third party payers. Bills requesting payment will usually include information which identifies you, your diagnosis and any procedures or supplies used. It may also be necessary to release Protected Information to obtain prior approval for treatment from your health insurance.

We will use your health information for regular health operations.
Your Protected Information may be used for facility operations which are necessary to ensure our office provided the highest quality of care. For example, your Protected Information may be used for learning or quality assurance purposes. We may also remove information which could identify you from your record so as to prevent others from learning who the specific patients are.

Emergency Use:
In an emergency situation exists and providing you with this notice is not practicable, we may use or disclose Protected Information to the extent necessary during the emergency.

Notification:
Unless you have informed us otherwise, your Protected Information may be used or disclosed by us to notify or assist in notifying you, a family member, or other person responsible for your care. This may include, but not limited to, voicemail messages, postcards or letters. In most cases Protected Information disclosed for notification purposes will be limited to your name, location and general condition.

Research:
Your Protected Information may be used or disclosed for research purposes. All research projects which use Protected Information are subject to a special approval process which will, among other things, evaluate the precautions used to protect patient medical information. In some cases,information which identifies you as the patient will be removed.

Special Circumstances
The law specifically requires us to use or disclose Protected Information in the following special circumstances:

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Health Care Oversights:
Your Protected Information may be used or disclosed to a health oversight agency for activities authorized by law. Examples of health oversight activities include audits, investigations, inspections or judicial/administrative proceedings which you are not the subject of. In most cases, the oversight activity will be for the purpose of overseeing the care rendered by our office or our office's compliance with certain laws and regulations.

Judicial and Administrative Procedures
If you are involved in a lawsuit or other administrative proceedings, we may release Protected Information in response to a court or administrative order requesting the release. In some instances, we may also release Protected Information pursuant to a subpoena or discovery request but only if efforts have been made by the requestor to provide you with notice of the request and you have failed to object or the objection was resolved in a favor of disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.

Victims of Abuse or Neglect:
We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This Protected Information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others. If you are incapacitated and unable to agree to such a disclosure, we may release your Protected Information for this purpose but only if failure to release it would materially and adversely affect a law enforcement activity and the information will not be used, in any way, against you.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid court order, warrant, subpoena/summons or administrative request.

Communication With Family:
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your Protected Information relevant to that person's involvement in your care or payment related to your care, only if you agree that we may do so.

Coroner, Medical Examiners, Funeral Directors:
We may disclose Protected Information to a coroner, medical examiner and to funeral directors consistent with applicable law to carry out their duties.

Diana Smith, ARNP
Certified Family Nurse Practitioner
Specializing in Adult & Pediatric ENT
Specializing in Cosmetic & Skin Care

Tracey G. Wellendorf, M.D.
Board Certified in Otolaryngology/
Head & Neck Surgery

Rebecca McCann, ARNP
Certified Family Nurse Practitioner
Specializing in Adult & Pediatric ENT

Specializing in the Medical and Surgical Treatment of Adult and Pediatric Head & Neck Diseases
• Allergies/Sinus Medicine & Surgery • Airway Surgery • Diseases of the Ear • Reconstructive Surgery of the Head & Neck
• Facial Plastics • Balance Disorders • Hearing Impairments

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

_____
_____
_____
_____

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 Represenative (if applicable) Relationship to Patient

Office Use Only:
Account# _____