

**EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS**

PATIENT INFORMATION						PATIENT # _____
LAST NAME	FIRST NAME	M.I.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH / /		
ADDRESS			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	SOCIAL SECURITY NO. - -		
CITY		STATE	ZIP CODE	EMAIL		

HOME PHONE	PREF <input type="checkbox"/>	CELL PHONE	PREF <input type="checkbox"/>	WORK PHONE	PREF <input type="checkbox"/>
EMPLOYER		OCCUPATION		PREFERRED LANGUAGE <input type="checkbox"/> DECLINE	
RACE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> WHITE/CAUCASIAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> ASIAN	ETHNICITY <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> HISPANIC OR LATINO		<input type="checkbox"/> DECLINE	
EMERGENCY CONTACT NAME		RELATIONSHIP	PHONE		

RESPONSIBLE PARTY / GUARANTOR

SELF - BY CHECKING HERE I CERTIFY THAT I, THE PATIENT, AM THE RESPONSIBLE PARTY AS I AM OVER 18 YEARS OF AGE

GUARANTOR LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH / /	SOCIAL SECURITY NO. - -	
ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE		CELL PHONE		WORK PHONE	
RELATIONSHIP TO PATIENT		EMPLOYER		OCCUPATION	

PRIVACY / HIPAA ACKNOWLEDGEMENTS

HIPAA Acknowledgements: All patients must check all that apply

- I acknowledge that I have been provided with a copy of the Eastern VA ENT Specialists Notice of Privacy Policy
- NO messages should be left on any voicemail or with anyone other than the patient
- Is it ok to leave a message regarding your health information at your : Home Cell
- By default, no other persons may have access to my medical record except the following people:

Initial to
approve

NAME/RELATIONSHIP

NAME/RELATIONSHIP

INSURANCE INFORMATION

FOR YOUR CONVENIENCE, WE WILL ASSIST YOU WITH THE INFORMATION NECESSARY TO FILE YOUR INSURANCE. PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS.

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
ID NO.	GROUP NO.	ID NO.	GROUP NO.
SUBSCRIBER'S NAME	DATE OF BIRTH / /	SUBSCRIBER'S NAME	DATE OF BIRTH / /
RELATION TO PATIENT	SS# - -	RELATION TO PATIENT	SS# - -

DEEMED CONSENT - CONSENT FOR TREATMENT - RELEASE OF MEDICAL INFORMATION - ELECTRONIC COMMUNICATIONS - NO GUARANTEE

- Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infection of HIV or hepatitis B or C viruses, and have results released to the exposed employee.
- I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as any testing and/or treatment carried out by Eastern Virginia Ear, Nose & Throat Specialists.
- I agree that Eastern Virginia Ear, Nose & Throat Specialists may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
- We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not share your information and you may opt out at any time.
- Chaperones may be present during examinations. Any request for a chaperone made by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. If patient is under 18 years of age a legal guardian must be present for appointments.

FINANCIAL AGREEMENT - INSURANCE AGREEMENT

- I hereby authorize treatment to patient by any Eastern Virginia Ear, Nose & Throat Specialists provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs of collection should such action become necessary.
- I understand that I have the right to choose to have or not have all recommended testing by the provider, but if the testing is performed, I am fully responsible for any charges left to my responsibility after insurance has processed the claim.

SIGNATURE OF PATIENT/GUARANTOR ➔	RELATIONSHIP TO PATIENT	DATE
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 www.easternvaent.com

New Patient ROS

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Primary Care Physician: _____

Height: _____ Weight: _____

What is your Ear, Nose, and/or Throat complaint that we are seeing you for today?

REVIEW OF SYSTEMS

Please **CHECK** if you are **CURRENTLY** having any of these symptoms

HEENT

- Blurred Vision
- Ear Discharge
- Ear Infection
- Ear Pain
- Eye Redness
- Frequent Colds
- Hearing Loss
- Hoarseness
- Nasal Congestion
- Nose Bleeds
- Oral Ulcers
- Ringing in the Ears
- Seasonal Allergies
- Sinus Pain
- Sore Throat
- Visual Disturbances
- Voice Changes

GENERAL

- Chills
 - Fever
 - Fatigue
- #### NECK
- Neck Mass
 - Neck Pain
 - Swollen Glands

RESPIRATORY

- Cough
- Difficulty Breathing
- Snoring

CARDIAC

- High Blood Pressure
- Shortness of Breath

GASTROINTESTINAL

- Difficulty Swallowing
- Indigestion
- Nausea
- Vomiting

MUSCULOSKELETAL

- Joint Pain
- Muscle Pain

NEUROLOGICAL

- Decreased Sense of Smell
- Dizziness
- Headache

ENDOCRINE

- Appetite Changes
- Cold Intolerance
- Thyroid Problems

HEMATOLOGICAL

- Abnormal Bleeding
- Anemia
- Easy Bruising

FOR MD USE ONLY

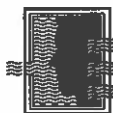
Allergy Inhalant Testing Audio/Tymp Follow Up ENT: _____

Total IgE Labs Follow Up Allergy: _____

Foods (IgE/IgG) VNG/ABR Follow Up Audiology: _____

Consults/Referrals: _____ Follow Up Audio/ENT: _____

Radiology: _____



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MEDICAL HISTORY

Name: _____ Today's Date: _____
 Date of Birth: _____ Family Doctor/PCP: _____
 Pharmacy Name: _____ Pharmacy Phone Number: _____
 Pharmacy Address: _____
 Preferred Language: _____ Occupation: _____
 Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced
 Race: ___ White ___ African American ___ Asian ___ American Indian ___ Pacific Islander
 ___ Other ___ Decline to Answer
 Ethnicity: ___ Hispanic ___ Non-Hispanic ___ Decline to Answer

MEDICAL PROBLEMS

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS

ENT

- Allergies
- Asthma
- Dizziness
- Ear Infections
- Eustachian Tube Dysfunction
- Hearing Loss
- Meniere's disease
- Nasal Polyp
- Neck Mass
- Parotid Gland Abnormality
- Perforated Ear Drum
- Reflux/GERD
- Sinusitis
- Sleep Apnea
- Thyroid Gland Abnormality
- Tinnitus
- Tonsillitis
- Other: _____

GENERAL MEDICAL

- Anemia
- Arthritis
- Birth Defects
- Cancer
- Diabetes
- Emphysema
- Glaucoma
- Heart Disease
- Hypertension (High Blood Pressure)
- Hepatitis
- HIV
- Osteoporosis
- Seizures
- Skin Disease
- Stroke
- Tuberculosis
- Urinary Problems
- Venereal Disease

ALLERGIES TO MEDICATION

PLEASE LIST ALL OF YOUR MEDICATION ALLERGIES AND REACTIONS NO KNOWN ALLERGIES (CHECK)

Do you have an allergy to Latex? ___ Yes ___ No

Do you have an allergy to Intravenous Dye? ___ Yes ___ No

Do you have any allergies to foods? ___ Yes ___ No Please list: _____

FAMILY HISTORY

Allergy ___ Yes ___ No
Asthma ___ Yes ___ No
Bleeding Disorder ___ Yes ___ No
Cancer ___ Yes ___ No
Thyroid Disorder ___ Yes ___ No

Relative: _____
Relative: _____
Relative: _____
Relative: _____
Relative: _____

SOCIAL HISTORY

Tobacco Use: ___ Yes ___ No ___ Former
Packs/Day: _____
Tried to Quit: ___ Yes ___ No
Are you exposed to second hand smoke: ___ Yes ___ No

Do you smoke daily: ___ Yes ___ No
How many years have you smoked: _____
Year you Quit: _____

Alcohol Use: ___ Yes ___ No

Frequency: ___ Daily ___ Weekly ___ Monthly ___ Rarely

Recreational Drug Use: ___ Yes ___ No

If yes, what type: _____

Pets: ___ Dog ___ Cat ___ Horse ___ Bird

Other, please list: _____

Are you currently pregnant: ___ Yes ___ No

If Yes, how many weeks: _____

MEDICATIONS

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS

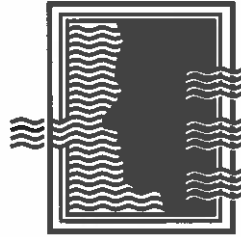
NO MEDICATIONS (CHECK)

SURGICAL HISTORY

PLEASE LIST YOUR SURGICAL HISTORY AND DATE OF SURGERY

NO SURGICAL HISTORY (CHECK)

Jeffrey P. Powell, M.D., D.D.S., F.A.C.S.
Charles H. Dennis, M.D. *Emeritus*
Alan S. Keyes, M.D., F.A.C.S.
Kimberly Pasquale, M.D., F.A.C.S.
Richard F. Debo, M.D., F.A.C.S.
Ryan P. Hester, M.D.
David W. Leonard, M.D., F.A.C.S.
Kenneth L. Mayes, M.D. *Emeritus*
Kim Scott, F.N.P., A.E.-C, CORLN
Alexis L. Buettner, MPA, PA-C



EASTERN VIRGINIA
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SPECIALISTS

Administrator - Melanie Hoy
Audiology - Paula A. Abraham, Au.D., CCC-A
Stephanie R. Howard, M.A., CCC-A
Stephanie M. Collins, Au.D., CCC-A
Michael W. Lemay, Au.D., CCC-A

IMPORTANT INFORMATION

PLEASE READ

Consent to perform in-office procedure/surgery
(Nasal Endoscopy or Laryngoscopy)

The purpose of this form is to make you aware of a certain charge that may apply to your visits if you are complaining of sinus, ear or throat problems.

If you are here for a consultation, follow-up or post op visit, it may be necessary for the doctor, nurse practitioner or physician assistant do a certain procedure (Nasal Endoscopy or a Laryngoscopy) in your evaluation and treatment. According to The American Medical Association the procedures, Nasal Endoscopy and Laryngoscopy, are re-classified as an in-office procedure/surgery. Insurance companies sometimes apply these procedures/surgeries to your coinsurance and/or deductible. Therefore, you may owe more than just your office co-payment for today's services. If you have any questions about your specific insurance plan benefit and your financial responsibility, please ask our financial advisor before seeing the provider. Please indicate your understanding and consent of these procedures by signing below.

- I understand and give consent** to a Nasal Endoscopy or Laryngoscopy for my evaluation and/or treatment if the provider finds it medically necessary.
- I understand BUT do NOT give consent** to a Nasal Endoscopy or Laryngoscopy. I understand without the procedure it will be very difficult for the provider to give me a proper diagnosis and treatment of my illness.

Patient Name

Date

Signature of Patient or Guardian

Relationship to patient

Witness

Date