EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS

PATIENT INFORMATION

PATIENT # _____

LAST NAME	FIRST NAME	M.I.	SEX ☐M ☐F	DATE OF BIRTH / /
ADDRESS			MARITAL STATUS ☐S ☐M ☐D ☐W	SOCIAL SECURITY NO. - -
CITY	STATE	ZIP CODE	EMAIL	
HOME PHONE PREF ☐	CELL PHONE PREF ☐		WORK PHONE PREF ☐	
EMPLOYER	OCCUPATION		PREFERRED LANGUAGE ☐ DECLINE	

RACE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE/CAUCASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ OTHER_____ ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ DECLINE

ETHNICITY ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ 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

Initial to approve _____

___ 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:

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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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	Relative:_____
Asthma	___ Yes ___ No	Relative:_____
Bleeding Disorder	___ Yes ___ No	Relative:_____
Cancer	___ Yes ___ No	Relative:_____
Thyroid Disorder	___ Yes ___ No	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
Pets: ____ Dog ____ Cat ____ Horse ____ Bird
Are you currently pregnant: ____ Yes ____ No

If yes, what type: _____
Other, please list: _____
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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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