HAGEN BEYER

EAR, NOSE, THROAT, AND SINUS CLINIC

PATIENT COMMUNICATION FORM

A. **Family and Friends**. It is the office policy of Hagen ENT Clinic not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse/Partner: _____ _____ yes _____ no

Parent: _____ _____ yes _____ no

Other:_____ _____ yes _____ no

May we leave a message on your answering machine? _____ yes _____ no

May we contact you via Mail? _____ yes _____no

May we call your Cell Phone? _____yes _____no

May we text or email you? _____yes _____no

B. **Alternative Communications**. You are also entitled to specify alternative, reasonable means of communication, **if you do not wish to be contacted by us in a certain way**.

I hereby request the following means of contact only:_____

_____

_____

PRINTED NAME_____

Patient/Parent/Guardian Signature:_____

Date: _____

HAGEN BEYER SIMON

PATIENT HISTORY FORM

HEIGHT:_____ WEIGHT:_____

Name: _____Date Of Birth: _____

What medical problem brings you here today? _____

- Location of Symptom(s):_____
- How severe is the problem: **1 2 3 4 5 6 7 8 9 10**
- How long have you had the problem? _____
- When does it occur or recur? _____
- Is it made better or worse with any treatment? _____
- List any associated symptom(s). _____

• PAST MEDICAL HISTORY

Ear, Nose & Throat:
- ☐ Ear Infections
- ☐ Sinus Infections
- ☐ Allergies
- ☐ Throat Problems
- ☐ Voice Problems
- ☐ Swimmers Ear

Lung:
- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Sleep Apnea

Kidney:
- ☐ Kidney Failure
- ☐ Incontinence
- ☐ Prostate Problems
- ☐ Bladder Problems

Heart:
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Abnormal Heart Valve
- ☐ High Blood Pressure

Endocrine:
- ☐ Diabetes
- ☐ Thyroid

Rheumatologic:
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Autoimmune Disorder

Gastrointestional:
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Hepatitis
- ☐ Cirrhosis

Eyes/Dermatologic:
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Keloids
- ☐ Skin Conditions

Neurologic:
- ☐ Stroke
- ☐ Headache
- ☐ Seizures
- ☐ Multiple Sclerosis

Hematologic/Infectious:
- ☐ Anemia
- ☐ Mononucleosis
- ☐ HIV
- ☐ Lyme Disease
- ☐ Bleeding Disorder

Psychiatric:
- ☐ Depression
- ☐ Anxiety

Oncologic:
- ☐ Cancer: List Type(s) _____

• PAST SURGICAL HISTORY

Ear, Nose & Throat:
- ☐ Ear
- ☐ Nose/Sinus
- ☐ Tracheotomy
- ☐ Tonsillectomy / Adenoidectomy

Gastrointestinal:
- ☐ Surgery for reflux
- ☐ Intestinal Surgery
- ☐ Stomach Surgery
- ☐ Gallbladder

Heart:
- ☐ Pacemaker
- ☐ Carotid Artery
- ☐ Valve Surgery
- ☐ Stent
- ☐ Bypass

Orthopedic:
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Fracture
- ☐ Back Surgery

Pelvic:
- ☐ Kidney Surgery
- ☐ Bladder
- ☐ D&C
- ☐ Gyn Surgery
- ☐ Prostate

Lung/Other:
- ☐ Bronchoscopy
- ☐ Breast
- ☐ Neurosurgery
- ☐ Eye

• MEDICATIONS

Please list ALL medications (or provide a list on a separate paper). Please include all over the counter medications also.

MEDICATION	DOSE	REASON

- **ALLERGIES**

Please list all allergies to medications and foods.

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

- **FAMILY HISTORY**

Check if any of these run in the family (only those related by blood):

☐ Autoimmune Disease	☐ Diabetes	☐ High Blood Pressure
☐ Heart Disease	☐ Hearing Loss	☐ Tuberculosis
☐ Problems with Anesthesia	☐ Thyroid Disease	☐ Bleeding/Coagulation Disorder

- **SOCIAL HISTORY**

Occupation: current: _____ previous: _____

Noise Exposure:	☐ At Work	☐ In Military	☐ Noise from Hobbies
Caffeine:	☐ Coffee	☐ Tea	☐ Caffeinated soft drinks

Tobacco: ☐ Never Smoked Current Smoker: Amount ____ per day # yrs smoking _____ Former Smoker: Quit _____

Alcohol: ☐ Never Drank Alcohol Drink Currently (please circle) : Daily Occassionally

- **SPECIAL CONCERNS**

☐ Latex Allergy ☐ Taking Blood Thinners ☐ Pregnant (Due _____) ☐ Breastfeeding ☐ Require antibiotics for procedures

- **REVIEW OF SYSTEMS**

Check other active systems

Constitutional:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Loss of Appetite

Cardiovascular:
☐ Chest Pain
☐ Fainting
☐ Irregular Heart

Respiratory:
☐ Shortness of Breath
☐ Cough
☐ Coughing up Blood
☐ Wheezing

Eyes:
☐ Recent Change in Vision
☐ Per-Orbital Swelling

Gastrointestinal:
☐ Trouble Swallowing
☐ Heartburn
☐ Bloody Vomiting

Genitourinary:
☐ Urinary Retention

Integument:
☐ Changes to Existing Skin Lesion

Psychiatric:
☐ Anxiety
☐ Depression
☐

Neurologic:
☐ Weakness
☐ Seizures
☐ Numbness

Endocrine:
☐ Heat Intolerance
☐ Cold Intolerance

Hematology / Lymphatic:
☐ Easy Bleeding
☐ Excessive Bleeding with Previous Surgeries
☐ Easy Bruising

Allergy / Immunology:
☐ Eczema
☐ Asthma
☐ Allergic Conjunctivitis (red eyes)

Head / Ears / Nose / Throat:
☐ Headache
☐ Vertigo (Spinning Sensation)
☐ Dizziness
☐ Lightheadedness
☐ Recent Head Injury
☐ Sinus Pain
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Nosebleeds
☐ Nasal Discharge
☐ Ear Discharge
☐ Ear Fullness
☐ Itching in Ear
☐ Ear Swelling
☐ Pressure Sensation in Ear
☐ Deviated Septum
☐ Decreased Sense of Smell
☐ Snoring
☐ Oral Ulcers
☐ Oral Sores
☐ Nasal Pain
☐ Purulent Nasal Discharge
☐ Gingival Bleeding
☐ Dental Problems
☐ Dentures
☐ Neck Stiffness
☐ Neck Pain
☐ Neck Tenderness
☐ Thyroid Mass
☐ Sore Throat
☐ Breath Odor
☐ Ear Pain
☐ Hearing Loss
☐ Ringing in Ears
☐ Roaring Sound in Ear
☐ Pulsatile Tinnitus
☐ Oral Blisters
☐ Oral White Spots
☐ Mouth Pain
☐ Dry Mouth
☐ Enlarged Tonsils
☐ Frequent Throat Clearing
☐ Lump in Throat
☐ Hoarseness
☐ Change in Voice
☐ Difficulty Swallowing
☐ Neck Mass
☐ Swollen Glands
☐ Neck Swelling
☐ Hearing Aid

Patient Signature: _____ **Date:** _____

HAGEN BEYER SIMON ENT CLINIC APMC

PATIENT FACE SHEET

Patient Chart No.:

Patient Name: _____ Today's Date: _____

D.O.B: _____ Age: _____ Sex: ____ Marital Status: _____ Home Phone: _____

SSN: _____ Cell Phone: _____

Mailing Address: _____ Apt. No.: _____

City, State, Zip: _____

Patient's Employer Name: _____ Work Phone: _____

Patient's Employer Address: _____ City, State, ZIP_____

Emergency Contact: _____ Home Phone: _____ Cell Phone:_____

Referral Information: Family Doctor: _____ How were you referred to our facility? _____

If a physician has referred you to our facility, please provide the physician's name: _____

If Patient is a Child: Father's Name: _____ Phone: _____

Place of Employment: _____

Mother's Name: _____ Phone: _____

Place of Employment: _____

Guarantor Name *(Financially responsible party)*:

Name: _____ D.O.B.: _____ SSN: _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Information: _____ Relationship to Insured: _____

Insured Name: _____ D.O.B.: _____ SSN: _____

Secondary Insurance Information: _____ Relationship to Insured: _____

Insured Name: _____ D.O.B.: _____ SSN: _____

************FEES ARE DUE AND PAYABLE UPON COMPLETION OF ALL SERVICES************

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, ***I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ALL PROFESSIONAL SERVICES RENDERED***. I HAVE READ ALL THE INFORMATION AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

PATIENT/GUARDIAN OF MINOR: _____ DATE: _____

************INSURANCE AUTHORIZATION AND ASSIGNMENT************

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER OF SERVICES FOR MYSELF AND/OR DEPENDENTS. ***I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE OR AMOUNTS FOR SERVICES NOT COVERED BY THE INSURANCE CARRIER***.

PATIENT/GUARDIAN OF MINOR: _____ DATE: _____

HAGEN BEYER

EAR, NOSE, THROAT, AND SINUS CLINIC

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A Professional Medical Corporation
David L. Hagen, M.D.
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Kaya Eschete, FNP-C Nurse Practitioner
Roxanne Hebert, LicHIS Hearing Instrument Specialist
Heather L. Bartley, Au.D. Audiologist

WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____. I hereby acknowledge receipt of **Hagen ENT Clinic, APMC**'s Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of **Hagen ENT Clinic, APMC**'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

HAGEN ENT CLINIC, APMC

REVISED 9/1/2013
EFFECTIVE IMMEDIATELY

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available upon request.

This information is made available on request by a patient

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

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please request the detailed Notice of Privacy Practices