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: __________________________
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

Gastrointestinal:
☐ 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.

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<th>MEDICATION</th>
<th>DOSE</th>
<th>REASON</th>
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• **ALLERGIES**
  Please list all allergies to medications and foods.

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<th>ALLERGY</th>
<th>REACTION</th>
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• **FAMILY HISTORY**
  Check if any of these run in the family (only those related by blood):
  - Autoimmune Disease
  - Diabetes
  - Heart Disease
  - Hearing Loss
  - High Blood Pressure
  - Hearing Loss
  - Thyroid Disease
  - Tuberculosis
  - Problems with Anesthesia
  - Tuberculosis
  - 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 Occasionally

• **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
  - At Work
  - In Military
  - Noise from Hobbies

  **Cardiovascular:**
  - Chest Pain
  - Fainting
  - Irregular Heart
  - Coffee
  - Tea
  - Caffeinated soft drinks

  **Respiratory:**
  - Shortness of Breath
  - Cough
  - Coughing up Blood
  - Wheezing
  - Recent Change in Vision
  - Per-Orbital Swelling
  - Trouble Swallowing
  - Heartburn
  - Bloody Vomiting
  - Urinary Retention
  - Changes to Existing Skin Lesion
  - Anxiety
  - Depression
  - 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

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

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

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