



FARRAGUT
ENT & Allergy



**The BALANCE and
HEARING INSTITUTE**
PATIENT INFORMATION



KNOXVILLE
Center for Facial Plastic Surgery

Name: _____ SSN: _____ DOB: _____ Sex: M F Race: _____ Ethnicity: Hispanic Latino None Street Address: _____ City: _____ State: _____ Zip Code: _____ Primary #: _____ Home Work Cell Secondary #: _____ Home Work Cell Email Address: _____ Marital Status: Single Married Widowed Divorced Employer: _____ Occupation: _____ Primary Care: _____ Referring: _____	<p style="text-align: center;">Primary Insurance</p> Company: _____ Insured Name: _____ DOB of Insured: _____ <p style="text-align: center;">Secondary Insurance (If Applicable)</p> Company: _____ Insured Name: _____ DOB of Insured: _____ <p style="text-align: center;">Person Responsible for Bill</p> Name: _____ Contact #: _____
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Emergency Contact Name: _____ Phone #: _____

FOR MINORS

Who is accompanying patient? _____ Relationship to Patient: _____

PATIENT MEDICAL INFORMATION

What are you seeing the Doctor for? _____

Severity of problem (scale 1-10, 10 being worst): _____ How long has this bothered you? _____

What makes it better? _____

Is it related to other problems? _____

Have you been treated for this before? By whom? _____

Smoking Status: Every Day Smoker Some Days Smoker Former Smoker Never Smoked

How much alcohol do you drink? _____ Do you use recreational drugs? _____

PHARMACY

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____



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MEDICAL HISTORY

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Emphysema | <input type="checkbox"/> TMJ | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> GERD | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> COPD | <input type="checkbox"/> DVT | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Exposure | <input type="checkbox"/> Cancer (type): _____ |
| <input type="checkbox"/> Bleeding Disorder | | | _____ |

MEDICATIONS

Medication	Dose	Taken for?

ALLERGIES

Please list **ALL** drug allergies: _____

FAMILY HISTORY

Hypertension: _____ Thyroid Disease: _____
 Heart Disease: _____ Diabetes: _____
 Hearing Problems: _____ Hearing Aids: _____
 Arthritis: _____ Bleeding Problems: _____
 Cancer: _____ Anesthesia Problems: _____

SURGICAL HISTORY

1: _____ Date: _____
 2: _____ Date: _____
 3: _____ Date: _____
 4: _____ Date: _____
 5: _____ Date: _____
 6: _____ Date: _____
 7: _____ Date: _____



REVIEW OF CURRENT SYMPTOMS

GENERAL

- Fever
- Weight Loss
- Fatigue

CARDIO

- Chest Pain
- Palpitations

PULMONARY

- Short of Breath
- Cough
- Wheezing

ENDO

- Hot/Cold Intolerance
- Thyroid Trouble/Goiter
- Bleeding Tendencies

HEAD, EYES, EAR, NOSE, THROAT

- Blurred Vision
- Eye Pain
- Itchy Eyes
- Hearing Loss
- Ear Noise
- Ear Pain
- Sneezing
- Allergies
- Runny Nose
- Stuffy Nose
- Snoring
- Hoarse

GI

- Abdominal Pain
- Diarrhea
- Constipation
- Heartburn
- Bloody/Dark Stools

MUSC/SKEL

- Rash
- Jaw Pain
- Joint Swelling/Pain
- Back Trouble
- Edema

NEURO

- Headaches
- Head Trauma
- Depression
- Numbness
- Tremors

GU

- Frequent Urination
- Painful Urination
- Pregnancy
- Vaginal Bleeding

OTHER

- Blood Transfusion
- HIV
- Nervous Breakdown

Who would care for you if you had surgery? _____

PLEASE NOTE: We recommend all patients over 50 obtain hearing evaluation due to the associated risk of dementia. Your doctor will utilize this information to ascertain your risks and make appropriate recommendations.

The information provided within this form is true and accurate to the best of my knowledge.

Patient Signature (Parent or Legal Guardian if Minor)

Date

Patient Name (Printed)



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PRACTICE POLICIES

(Please initial by each and sign at the bottom)

_____ **FINANCIAL POLICY** IT IS THE POLICY OF THIS OFFICE THAT ALL PAYMENTS BE MADE EACH VISIT AND I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. I request that payment of authorized insurance benefits be made to me on my behalf to Otolaryngology Head and Neck Surgery Associates/ Farragut ENT Allergy for services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I will notify the office of any changes in the above information.

_____ **LIMITATION OF LIABILITY** In no event shall Otolaryngology Head & Neck Surgery Associates or any other party involved in the creation, production, or delivery of the Electronic Health Record system, or any software application associated with the Electronic Health Record be liable for any direct, indirect, special, incidental, consequential, or punitive damages of any kind, or any damages whatsoever resulting from computer virus or system failure, or loss of data, or electronic record errors either by the software producer or the medical provider arising out of or in connection with the use or performance of the Electronic Health Record, or users' inability to use the content contained within the Electronic Health Record on any theory of liability. Otolaryngology Head & Neck Surgery Associates assumes no liability or responsibility for any loss or damage incurred caused by or arising from your reliance on the content of the Electronic Health Record.

_____ **SURGERY** If your physician recommends surgery, you will talk to the surgery scheduler. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all precertification/authorization if your insurance company requires it. Please note while our staff will attempt to precertify/prior authorize or pre-determine the requirements of your insurance it may become necessary for you to handle this process if we are unsuccessful in our attempts. If authorization is obtained, please understand your insurance company still applies a disclaimer stating "authorization is not coverage of said procedure, coverage will be determined at the time the claim is received and is not a guarantee of payment". Pre-surgical deposits of 50% of your estimated surgical cost will be required prior to scheduling your surgery. The remaining 50% will be required one week prior to surgery.

_____ **MINOR POLICY** A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

_____ **LATE CANCELLATION/NO SHOW POLICY** In order to provide appropriate medical care and prevent scheduling delays we reserve the right to dismiss from our practice any patient who has 3 no shows/late cancellations (less than 24 hours notice) in a 12-month period.

Non-Covered Service Fees

◆\$20 copying of medical records other than continuation of care ◆\$45 completion of patient initiated medical forms ◆\$50 returned check fee
◆\$10 statement fee for failure to pay co-pay/balance at time of service ◆\$10 statement fee for request to re-file appropriately filed claims after receipt of denial or failure to give correct insurance information ◆\$25 failure to cancel office appointment without 24 hour notice ◆\$250 failure to cancel ALLERGY testing appointment without 5 business days notice ◆\$250 failure to cancel SURGERY without 5 business days notice.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility. I authorize my insurance benefits be paid directly to Farragut E.N.T. & Allergy. I authorize Farragut E.N.T. & Allergy to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. In the event there is a question of standard of care in any procedure, diagnosis, or other service by Farragut E.N.T. & Allergy, or its employees, I agree to an arbitration process at FENT's discretion and only using expert witnesses certified or approved by the American Academy of Otolaryngology Head and Neck Association or those agreeable to Farragut E.N.T. & Allergy. The practice reserves the right to discontinue care/treatment to the patient if the patient or parent/guardian is non-compliant, inappropriate, or abusive with staff or is delinquent on their account.

Patient Signature

Patient Name (Printed)

Date



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INFORMATION AUTHORIZATION

Effective April 14, 2003, Federal Regulations required healthcare providers not to give any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parent, other household members, relatives, etc., even when they call or come into Farragut E.N.T. & Allergy on your behalf or at your request, unless you have given us permission to talk to them.

Please tell us how we may contact you and whom we may disclose your health information.

Check all that apply:

- Home Phone: (____) ____ - _____
 - Cell Phone: (____) ____ - _____
 - Work Phone: (____) ____ - _____
 - Email Address: _____
 - I do not want information released to anyone other than myself, including my spouse
 - No restrictions, speak with whomever necessary in my behalf
 - Leave message on home answering machine
 - You may speak with anyone who answers my home telephone number
 - I would like appointment reminder calls
 - I wish to receive information by mail regarding services offered by this office
- You may speak with: my spouse my parent(s) person(s) I listed below

_____, about my medical condition(s) and treatment.

Obtain/release medical records from any participating healthcare facility/provider to help with continuing of my care via fax or postal mail.

◆ I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer.

◆ If I fail to specify an expiration date, this authorization will extend indefinitely. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this for in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.521. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for Farragut E.N.T. & Allergy at (865) 777-1727.

Patient Signature

Date Authorization Executed

Patient Name (printed)

Date of Birth



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Why are you seeing the Doctor today?

Follow up for _____ *(Type of problem)*

After Surgery _____ *(Type of surgery)*

New Problem _____

(Describe the Problem)

Our Doctors recommend several types of testing for many patients.

We recommend a hearing test for any patient over age 50. If you are over the age of 50, would you like to have a hearing test today?

- Yes
- No

We recommend a balance evaluation for any patient over age 65. If you are over 65, would you like to have a balance test?

- Yes
- No

Do you have any questions for the doctor today?

