ADULT PATIENT MEDICAL HISTORY

BROWARD ENT CONSULTANTS, PL

5511 North University Drive, Suite 101B
Coral Springs, FL 33067

Phone 954-755-4002 | Fax 954-755-5010
www.myENTmd.com

Name: _____

DOB:_____Height _____Weight _____

Today's date: _____

Referring doctor: _____

Previous ENT consultations: _____

What is the main reason for today's visit?

_____

How long has this been a problem?_____Hours__Days____Weeks___Months___Years

Have you taken any over the counter medications or prescription medication for this problem? If yes, please list.

_____

Have X-rays, CT scans, MRI's, sleep study or allergy tests been obtained for this problem? If yes, please list.

_____

Past and present medical history that require regular doctor visits or medication (please check)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Cancer(type) _____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eye Disease
- ☐ Emphysema/COPD
- ☐ Stroke
- ☐ Gastrointestinal problems/Acid Reflux/Hiatal Hernia
- ☐ Heart Disease/High Blood Pressure
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Leukemia/Lymphoma
- ☐ Liver/Kidney Disease
- ☐ Lupus/Autoimmune Disease
- ☐ Migraine/Headaches
- ☐ Recurrent Sinus Infections
- ☐ Sleep Apnea (Diagnosed by a physician)
- ☐ Thyroid Problems

Other, if not listed above_____

List ALL medications, including aspirin, herbal medications, over the counter medicines and vitamins you take on a regular basis with the doses

_____

_____

List any allergies to medications or substances (including latex / natural rubber):

_____

Family history: please list any blood relatives that have or have had any of the following:

- ☐ Hearing loss — How related_____
- ☐ Heart trouble — How related_____
- ☐ Bleeding / Clotting problems — How related_____
- ☐ Cancer — How related_____
- ☐ Asthma / Allergies — How related_____
- ☐ Sleep apnea / Uses CPAP — How related_____

Surgical History: (Please list all previous surgeries with approximate dates)

_____

_____

Social History:

Have you ever been a smoker? Yes ☐ No ☐ If yes_____ packs per day, _____years?

Smokeless Tobacco: Yes☐ No ☐

If you quit, how long ago?_____

Do you drink alcohol? Yes ☐ No ☐ If yes, how many drinks per day?_____ week _____ month _____

Who lives at home with you?_____

Review of systems:

Please check any medical problems you are currently having, including symptoms which contribute to today's visit.

BODY(GENERAL):
☐ Fatigue
☐ Trouble sleeping
☐ Weight loss/Weight gain
☐ Chronic Pain

EYES
☐ Blurred vision
☐ Glaucoma
☐ Itching
☐ Pain

EARS
☐ Ear infections
☐ Decreased hearing
☐ Ear fullness/dogging sensation
☐ Ear pain
☐ Dizziness / imbalance
☐ Ringing/noise in the ears
☐ History of noise exposure

NOSE
☐ Nasal discharge
☐ Nasal congestion/stuffiness
☐ Changes in sense of smell
☐ Nasal polyps
☐ Frequent colds
☐ Sinus Infections How many per year?
☐ Broken nose
☐ Nasal bleeding
☐ Allergies
☐ Sneezing

NECK
☐ Large glands
☐ Neck pain
☐ Lump/Cyst
☐ Thyroid problems

HEART
☐ Murmur
☐ Heart Surgery
☐ Heart Attack
☐ Chest Pain

LUNGS
☐ Asthma
☐ Wheezing
☐ Bronchitis
☐ Bloody cough
☐ Emphysema/COPD

STOMACH
☐ Heartburn
☐ Stomach Cramps
☐ Stomach Ulcer
☐ IBS

MUSCLE/BONES
☐ Joint Pain
☐ Joint Swelling
☐ Weakness
☐ Back Pain

THROAT
☐ Sore throat
☐ Tonsillitis Yearly, how many required antibiotics?
☐ Bad breath
☐ Hoarseness
☐ Snoring
☐ Noisy breathing
☐ Cough
☐ Throat drainage

PSYCH
☐ Depression
☐ Insomnia
☐ Anxiety/panic attacks

SKIN
☐ Eczema
☐ Itching
☐ Hives
☐ Rash
☐ Moles

GU
☐ Frequency
☐ Burning
☐ Stones
☐ Bleeding
☐ Infections

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PATIENT INFORMATION

Patient name:_____
Last First Middle

SSN:_____ Date of birth:_____ Sex: ☐F ☐M

Marital status: ☐single ☐married ☐widow/er ☐divorced

Home
Address:_____
Street city state zip code

Home phone:_____ Cell phone:_____

Work phone:_____ Spouse phone: _____

Primary care physician:_____ Phone _____

Pharmacy name:_____ Phone _____

Email address_____

Insured name_____ DOB_____

Insurance name_____ PPO/HMO

Insurance id #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. Madasu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature_____ Date_____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights, to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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CANCELLATION POLICY/NO SHOW POLICY/SAME DAY CANCELLATION

Cancellation/ No Show Policy for Dr. Madasu Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.
Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee. This will not be covered by your insurance company.

If you have a Monday morning appointment, we must hear back from you to confirm this appointment by Friday afternoon, otherwise your appointment will be cancelled.

I hereby understand that Dr. Madasu, Broward ENT consultations, will contact me the day before my appointment and if they do not receive a confirmation back the appointment will be cancelled.

Scheduled Appointments
We understand that delays can happen however we must try to keep the other patients and doctors on time.
If you arrive 15 minutes past your scheduled appointment time, we will have to reschedule the appointment.

Account balances
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patient/Guardian Signature: _____

Date: _____

Patient Account #: _____
(Office Use Only)

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AUTHORIZATION TO RELEASE INFORMATION

I HEARBY GIVE MY PERMISSION TO **BROWARD ENT CONSULTANTS** TO RELEASE A COPY OF MY MEDICAL RECORDS (ANY DIAGNOSTIC TESTING / ALLERGY TESTING / PHYSICIAN'S NOTES / VISIT NOTES / OP REPORTS OR OTHER LISTED BELOW)

OTHER _____ DATE _____
PATIENT'S SIGNATURE _____ DATE _____

ADDRESS: 5511 N UNIVERSITY DR. SUITE 1018 CORAL SPRINGS FL, 33067
PHONE NUMBER: 954-755 4002 FAX NUMBER: 954-755-5020

I HEARBY RELEASE THE FACITILY FROM ANY LIABILITY WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED

PATIENT'S NAME PRINTED _____ DATE _____
PATIENT'S NAME SIGNED _____ DATE _____

THE INDIVDIUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUALS NFORMATION OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITIES TO RECEIVE A COPY OF THIS AUTHORIZATION FORM UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHOR IZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PROVIDING ORGANIZATION IN WRITING, BUT IF I DO, IT WON'T HAVE ANY AFFECT ON ANY ACTIONS THEY TOOK BEFORE THEY RECEIVED THE REVOCATION

I HEARBY AUTHORIZE THE RELEASE OF MY RECORDS AND AUTHORIZATION TO DISCLOSE INFORMATION TO THE FOLLOWING

NAME _____ SIGNATURE _____
CONTACT _____ RELATIONSHIP _____
MINORS/REPRESENTATIVES/POWER OF ATTORNEY
PATIENT'S NAME _____ DATE OF BIRTH _____
MINORS/REPRESENTATIVES/POWER OF ATTORNEY

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
*YOU MAY NOT USE THIS FORM TO RELEASE INFORMATION FOR TREATMENT OR PAYMENT EXCEPT WHEN THE INFORMATION TO BE RELEASED IS PSYCHOTHERAPY NOTES OR CERTAIN RESEARCH INFORMATION