Commonwealth
ear nose and throat specialists pc

Patient Information

Referring Physician _____ Primary Care Physician _____
Patient's Full Name_____
Date of Birth_____/_____/_____ Age _____ Sex: ☐ Male ☐ Female Social Security # _____
Address_____ Apt. # _____
City_____ State_____ Zip code_____
Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Email Address _____Patient's Employer _____
Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email
Pharmacy Name _____ Pharmacy Number or Location _____
Race_____ Ethnicity_____ Language_____
Spouse's Name_____ Date of Birth_____/_____/_____
Spouse's Social Security # _____ Spouse's Phone _____
Spouse's Employer _____

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section below:
Father/Guardian's Name_____ SSN_____
DOB_____/_____/_____Phone(____)_____ Relationship to Patient _____
Address (If different from above) _____
Employer_____ Work Phone(____)_____
Mother/Guardian's Name_____ SSN_____
DOB_____/_____/_____Phone(____)_____ Relationship to Patient _____
Address (If different from above) _____
Employer_____ Work Phone(____)_____

Insurance Information

Insurance Company_____ Policy ID#_____ Group# _____
Policy Holder's Name_____DOB_____/_____/_____
Address _____Phone_____Relationship to Patient_____
Secondary Insurance Company _____ Policy ID#_____ Group# _____
Policy Holder's Name_____DOB_____/_____/_____
Address _____Phone_____ Relationship to Patient_____
Is today's visit pertaining to a motor vehicle accident or a workman's comp injury? ☐ **Yes** ☐ **No**
If you answer yes please complete the following information:
Insurance Company Name_____
Agent Name/Contact Name_____ Phone (____)_____
Claims/Billing Address_____
Claim#_____ Date of Accident or Injury_____

Patient Acknowledgement of Financial Responsibility

I hereby authorize Commonwealth ENT Specialists, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Commonwealth ENT Specialist, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

Referral Waiver

If a referral is required by the insurance carrier, it is the sole responsibility of the patient to provide Commonwealth ENT Specialist, P.C. with such referral or be held fully responsible for payment of services rendered.

_____ _____

Patient's Signature (or responsible party) Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

Signature Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

Consent For Use Or Disclosure of Patient Information For The Purposes of Treatment, Payment, & Healthcare

I hereby consent to Commonwealth ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

Patient's Consent for Provider to Disclose PHI to Authorized Persons

I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the person indicated below.

Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name	Relationship	Contact #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of Disclosure - The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

Expiration of Authorization - This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

Conditioning of Treatment - Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

Redisclosure by Recipient - I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

Acknowledgment of Reading and Agreement – I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

_____

If a Representative Signs, state the Representative's Authority

Date:_____

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Name_____ Date of Birth_____Age_____

Referring Physician_____ Primary Care Physician_____

Occupation_____ Employer_____

Please specifically give the reason for your visit: _____

If your reason involves an injury or injuries, please describe the nature and give dates: _____

Do you currently have, or have you ever been treated for any of the following conditions:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
  Type:_____
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Problems:_____
  _____
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver disease
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nasal Obstruction
- ☐ Pneumonia
- ☐ Psychiatric Problems
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
  ☐CPAP
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Other:_____
  _____
  _____

In the past 6 months, have you experienced:

☐Weight loss	☐Chest Pain	☐Joint Pain
☐Nausea/Vomiting	☐Shortness of breath	☐Headaches
☐Fever/Chills	☐Nasal Obstruction	☐Depression
☐Night Sweats	☐Muscle weakness	☐Sore throat
☐Fatigue	☐Difficulty Swallowing	☐Heartburn

Social History

Do you currently use tobacco? ☐Yes ☐No

Packs per day _____ How long? _____ years

If you smoked previously, when did you quit? _____

Does anyone in the house smoke? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

Indicate if drugs or alcohol ever posed a dependency problem for you: ____ Drugs _____ Alcohol

SURGERIES

☐ **Check if none**

List all surgeries you have had, including childhood surgeries such as tonsillectomy or ear tubes:

Surgery	Date	Surgeon/hospital

MEDICATIONS

☐ **Check if none**

List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

Medication	Dosage	Duration (How long?)

ALLERGIES TO MEDICATIONS

☐ **Check if none**

List any medications to which you are allergic:

Medication	Type of reaction

Do you or anyone in your immediate family have a history of bleeding problems? ☐No ☐Yes: explain_____

Do you or anyone in your immediate family have a history of anesthesia reactions? ☐No ☐Yes: explain_____

Do you have a history of bad scarring? ☐No ☐Yes: explain_____

For office use

☐ Dr. Bridges
☐ Dr. Gibbons

☐ Entered in EMR