Date: _____

Account # _____

LAKESIDE
ENT & Allergy
Head and Neck Surgery

*Board Certified Otolaryngologists*

## MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we can provide you with the best of care

Patient Name: _____ DOB: / / Age: _____
Please Print Last First

Reason for Visit: _____ Gender: ___ Male ___ Female

Occupation: _____ Patient Accompanied By: _____

PHARMACY INFORMATION:

Name: _____ Phone: _____

Address: _____

Primary Care Provider: _____ Doctor who Sent you here: _____

### PAST MEDICAL HISTORY

- ☐ ADD
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth History (ie Preemie, c-section, low birth weight)

  _____

  _____
- ☐ Bleeding Disorders
- ☐ Cancer (skin, thyroid, etc)
  Type: _____
- ☐ Depression/Anxiety
- ☐ Diabetes, Type I or II
  (Please circle I or II)
- ☐ Dizziness
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Gastric Reflux
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Lipids
- ☐ HIV
- ☐ Hoarseness
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraine Headaches
- ☐ Nasal Obstruction
- ☐ Restless Leg Syndrome
- ☐ Sleep Apnea
- ☐ Prior Sleep Study
  When: _____
  Where: _____
- ☐ Sinusitis
- ☐ Snoring
- ☐ Stomach Ulcer
- ☐ Strep Throat
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ Disorder
- ☐ Tonsillitis

☐ No Pertinent History ☐ Other: _____

### PAST SURGICAL HISTORY

Please include dates of surgery

☐ Ear Surgery _____ ☐ Neck Surgery (i.e. thyroid) _____ ☐ Vocal Cord Surgery _____

☐ Facial Surgery _____ ☐ Skin Lesion/Cancer Surgery _____

☐ Nasal/Sinus Surgery _____ ☐ Tonsillectomy/Adenoidectomy _____

☐ Other _____

### MEDICATION HISTORY

List current medications and dosage:

_____

_____

### DRUG ALLERGIES

Drug Allergies: ☐ No Known Drug Allergies ☐ Yes (if yes, please list and include reaction)

_____

## FAMILY MEDICAL HISTORY

- ☐ Bleeding Disorders
- ☐ Cancer
  Type: _____
- ☐ Family History Unknown
- ☐ Diabetes
- ☐ Environmental Allergies
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sleep Apnea
- ☐ Thyroid Cancer
- ☐ Thyroid Disease

## SOCIAL HISTORY

**Alcohol Usage**

- ☐ Currently Every Day
  Amount: _____ Type: _____
- ☐ Currently Some Days
  Amount: _____ Type: _____
- ☐ Former Age Quit: _____
- ☐ Never

**Tobacco Usage**

- ☐ Currently Every Day
  Amount: _____ Type: _____
- ☐ Currently Some Days
  Amount: _____ Type: _____
- ☐ Former Age Quit: _____
- ☐ Never

**Other**

- ☐ Do you live alone? (check for yes)
- ☐ Prior or Current Recreational Drug Use
- ☐ Other Risk Factors for HIV
  Explain: _____

## REVIEW OF SYSTEMS

Please check all symptoms which you have, or have had recently. If you have not experienced a medical problem under the symptom listed, check the NO Box.

### CONSTITUTIONAL SYMPTOMS

☐ fatigue ☐ fever ☐ difficulty sleeping
Other: _____
☐ No Constitutional Symptoms

### EYE SYMPTOMS

☐ eye discomfort ☐ changes in vision
Other: _____
☐ No Eye Symptoms

### CARDIOVASACULAR SYMPTOMS

☐ chest pain ☐ irregular heart beats
☐ lightheadedness
Other: _____
☐ No Cardiovascular Symptoms

### PSYCHIATRIC SYMPTOMS

☐ anxiety ☐ depression
Other: _____
☐ No Psychiatric Symptoms

### RESPIRATORY SYMPTOMS

☐ shortness of breath ☐ hoarseness ☐ cough
☐ wheezing
Other: _____
☐ No Respiratory Symptoms

### INTEGUMENT (SKIN) SYMPTOMS

☐ new skin lesions ☐ lumps
☐ change in mole appearance
Other: _____
☐ No Integument (skin) Symptoms

### ALLERGIC-IMMUNOLOGIC SYMPTOMS

☐ environmental allergies ☐ immune deficiency
Other: _____

### NEUROLOGICAL SYMPTOMS

☐ speech difficulties ☐ migraines ☐ dizziness ☐ headaches
☐ seizures ☐ numbness/tingling Other:
_____
☐ No Neurologic Symptoms

### MUSCULOSKELETAL SYMPTOMS

☐ muscular weakness ☐ twitching ☐ gait changes
☐ joint pain
Other: _____
☐ No Musculoskeletal Symptoms

### ENDOCRINE SYMPTOMS

☐ weight gain ☐ weight loss ☐ history of thyroid problems
☐ hot or cold intolerances
Other: _____
☐ No Endocrine Symptoms

### GASTROINTESTINAL SYMPTOMS

☐ nausea ☐ heartburn ☐ difficulty swallowing
☐ choking on liquids ☐ reflux
Other: _____
☐ No Gastrointestinal Symptoms

### HEME (BLOOD) – LYMPH SYMPTOMS

☐ swollen lymph nodes ☐ easy bleeding or bruising
Other: _____
☐ No Hemo(blood)-Lymph Symptoms

### OTHER PERTINANT INFORMATION WE SHOULD KNOW

LAKESIDE
ENT & Allergy

# Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing Lakeside ENT & Allergy! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department.

## Payment is Due At the Time of Service

- We accept cash, checks, debit, credit cards and Care Credit.
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.

_____ Initial here

- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.

_____ Initial here

- Patient-responsible balances are due when you check in for your appointment, unless prior arrangements have been made with the billing department.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient.

## Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance, address and phone number.

## Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file.
- Self-Pay patients, please be prepared to pay a minimum of $100 on the date of service for a new patient visit and a minimum of $50 for an established patient visit. We apply a 20% discount to the final bill. There may be additional fees for DME or other supplies or services. If you are unable to pay, please ask to speak to the billing department to make payment arrangements.

_____ Initial here

## Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

## Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

## Divorce and Child Custody Cases

- The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility*).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

## Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

_____ Initial here 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 copayments and deductibles, are my responsibility.

_____ Initial here I authorize my insurance benefits be paid directly to Lakeside ENT & Allergy.

_____ Initial here In order to properly treat me, I authorize Lakeside ENT & Allergy permission to view my prescription medication records.

_____ Initial here I authorize Lakeside ENT & Allergy to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

_____ Initial here I authorize Lakeside ENT & Allergy to contact or discuss my personal health information with:

| Name: | Relationship: | Contact #: |
|---|---|---|
| Name: | Relationship: | Contact #: |

**X** Patient/
Guarantor Signature _____ Date: _____

## Acknowledgement of Sample Practice Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of Lakeside ENT & Allergy's Notice of Privacy Practices.

**X** Patient/
Guarantor Signature _____ Date: _____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

# Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Lakeside ENT & Allergy LLC

| Patient Name | Date of Birth | Patient Identification Number |
|---|---|---|
| | | |
| Patient Address | | |
| | | |

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

**The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.**

**My Consent Choice.** ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, *even in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

| Signature of Patient or Patient's Legal Representative | Date |
|---|---|
| | |
| Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable) |
| | |