Patient Medical History Form

Date: ___________

Patient's Name: _____________________________________ Signature: ________________________________

Are you allergic to any medicine? ____ Yes ____No Age: _______________

If yes, please list: ____

What is your main complaint? ____

What medicine(s) are you or have you been taking for this? ____

When did your symptoms begin? ____

Please list the names of other doctors you have seen for this problem: __________________________________

Referring Doctor: ______________________________ Family Doctor: ___________________________________

Review of System:
Do you have any of the following:

____ Headaches
____ Double vision
____ Blocked nose
____ Asthma
____ Hayfever
____ Shortness of breath
____ Stomach pain
____ Ulcers
____ Nausea or vomiting
____ Blood in stools
____ Pain on urination
____ Chest pain
____ Heart murmur
____ High blood pressure
____ Diabetes
____ Arthritis
____ Reaction to anesthesia
    ____ Does anyone in your family?
____ Weight loss
____ Fever or chills
____ Difficulty swallowing
____ Pain on swallowing
____ Hoarseness
____ Coughing up blood
____ Earache
____ Bleed or bruise easily
    ____ Does anyone in your family?
____ Seizures
____ Recent trauma

Past Medical History:

List any surgical procedures or hospitalizations you have had in the past:
____

____

____

Family History:

Mother: ____ Alive ____ Deceased

Medical Problems: ______________________

____

Father: ____ Alive ____ Deceased

Medical Problems: ________________________

Other Family Members with Medical Problems:

____

Have you taken any aspirin in the last two weeks? ____ No ____ Yes If yes, when? ______________________
Please list current medications:
____
____

Tobacco Use: ____ Yes ____ No If yes, how much? ____
Alcohol Use: ____ Yes ____ No If yes, how much? ____

Patient Information

Last Name: ____ Occupation: _______________________________________

First & Middle Name: _______________________________________ Employer: ____

Address: ____ Work Address: _____________________________________

City, State: _________________________________ ZIP: _________ City, State: _________________________ZIP: _________

Home Phone #: ____ Work Phone #: _____________________________________

Social Security #: ____ Marital Status: ____ Single _____ Married ____ Separated

Date of Birth: _____/ _____/ ______ Age: ______ Sex: ________ ____ Divorced _____ Widowed

Have we ever seen any other member of your family? _____ If yes, who? ____

Responsible Party (If different from patient) ~ Parent or guardian if patient is a minor

Last Name: ____ Occupation: _______________________________________

First & Middle Name: ______________________________________ Employer: ____

Address: ____ Work Address: _____________________________________

City, State: _________________________________ZIP: _________ City, State: _________________________ZIP: _________

Home Phone #: ____ Work Phone #: _____________________________________

Social Security #: ____ Date of Birth: ____/ ____/ ______

Spouse or Other Parent

Last Name: ____ Occupation: _______________________________________

First & Middle Name: _______________________________________ Employer: ____

Address: ____ Work Address: ____________________________________

City, State: _______________________________ZIP: __________ City, State: _________________________ZIP: _________

Home Phone #: ____ Work Phone #: _____________________________________

Social Security #: ____ Date of Birth: ____/ ____/ ______

Insurance Information: (Please allow receptionist to copy cards)

Primary Insurance: ____ Policy #: ___________________________________

Name of Policy Holder: ____ Group #: ___________________________________

DOB: ____/____/_____ S.S. # ____________________________________

Secondary Insurance: ____ Policy #: ___________________________________

Name of Policy Holder: ____ Group #: ___________________________________

DOB: ____/____/_____ S.S. # ____________________________________

EMERGENCY CONTACT:

NAME: ____ ADDRESS: ____

TELEPHONE: ____________________________________ RELATIONSHIP: ____

Georgia Ear Associates
Richard E. Brownlee, MD, FACS
M. Miles Goldsmith, MD, FACS
J. Robert Logan, MD
Michael D. Poole, MD, FACS

Managed Care mandates that you use in-network physicians, hospitals, labs and services in order to receive in-network payment.

Failure to notify your provider of in-network requirements will result in nonpayment or penalty of payment by your insurance company and will result in your being billed for services rendered.

If referral numbers and/ or authorization for services requests are required by your plan, please notify this office prior to and services being rendered so that you will not be penalized. It is your responsibility to obtain referral numbers and/ or authorization from your primary care provider.

Please check your INSURANCE Company's preferred place of service.

Hospital:

_____ Memorial Health University Medical Center

_____ St. Joseph's/ Candler Health System

Labwork:

_____ Quest

_____ Memorial Hospital Laboratory

_____ Lab Corp (BCBS HMO, POS)

_____ St. Joseph's/ Candler

I have read the above information and I understand that I am responsible for bills that may arise due to inaccurate information given at this time. If you are unable to provide us with this information before you leave, we will send your labs to the most cost effective laboratory. This may NOT be the lab your insurance company prefers or will pay for.

Patient Signature: ____

Date of Birth: ____

Today's Date: ____

Financial Agreement

I hereby agree to pay for all office visits at the time services are rendered unless I make arrangements in advance. If hospitalization is necessary, I understand that payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that insurance does not relieve me of the responsibility to pay.

Date: ____________ **Signature**: ____

Authorization to Release Information

I hereby authorize Georgia Ear Associates to furnish my insurance company(s), hospital, referring physicians, and attorneys all information with regard to my medical care. This may include information related to HIV, substance abuse, sexually transmitted diseases, or psychiatric treatment.

Date: ____________ **Signature**: ____

Authorization for Assignment of Benefits

I hereby authorize payment directly to Georgia Ear Associates surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

Date: ____________ **Signature**: ____

Authorization for Medicare Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Georgia Ear Associates for any services furnished by the physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits payable to related services.

I understand my signature request that payment be made authorized and release of medical information necessary to pay the claim. If items 9 or HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge; I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon charge determination of the Medicare carrier.

Date: ____________ **Signature**: ____

Champus Release

I request that payment of authorized benefits be made either to me or on behalf to Georgia Ear Associates for any services furnished by that physician. I authorize any holder of medical information about me to be released to Champus and its agents to determine the benefits payable for related services.

Date: ____________ **Signature**: ____

Acknowledgement of Privacy Notice

I have received a copy of the *GEORGIA EAR Notice of Privacy Practices*, which details how my personal health information may be used and disclosed as permitted under federal and state laws. I have read and understand the contents of the notice.

Signature ____ Date _______________

If not signed by the patient, please indicate the relationship to the patient.

Relationship ______________________________________

Internal Use Only

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time) ____

By (name and title) ____