PATIENT INFORMATION FORM

We appreciate you taking the time to fill out these forms. Please answer completely.

Full Legal Name _____ Preferred Name _____

Mailing Address _____ City, State, Zip _____

Gender ☐ Male ☐ Female

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth _____ Age _____ SSN# _____

Employer _____

Primary Language _____

Which Doctor referred you to our office? (*First & Last Name*) _____

Who is your Primary Care Doctor? (*First & Last Name*) _____

Responsible Party Information (e.g., legal guardian of minor)

This section needs to be filled out **ONLY** if the patient is age 17 years and younger.

Is the patient age 17 or younger? ☐ Yes ☐ No

Parent/Guardian Name _____

Mailing Address _____ City, State, Zip _____

Gender ☐ Male ☐ Female

Date of Birth _____

Primary Phone _____

Employer _____

Patient's Relation to Responsible Party _____

Health Insurance Information

Despite providing your insurance cards, this section needs to be filled out completely to ensure we can bill your insurance correctly.

Is the patient insured? ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Company _____

Address _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber ID _____

Group # _____

Patient's Relation to Subscriber _____

Upload insurance card(s): Front- Back-

Is there a secondary insurance? ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Company _____

Address _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber ID _____

Group # _____

Patient's Relation to Subscriber _____

Front- Back-

Patient Name:_____ Age:_____ Date of Birth:_____

Emergency Contact *(not living with you)*

Name _____Relation _____ Phone_____

Mailing Address _____ City, State, Zip _____

Release of Medical Information / Authorization to Treat in the Absence of Legal Guardian

I authorize the doctors and staff at this medical practice and its affiliates to disclose protected health information such as office notes and diagnostic test results to the persons below (e.g., spouse or parent). Furthermore, I consent to my child or dependent to be treated in my absence when brought into the office by the below-named persons and as indicated by the checked box. This authorization shall be effective until I revoke it in writing.

Initials _____

Individual # 1 _____ Individual #2 _____

Relation to Patient _____ Relation to Patient _____

Phone _____ Phone _____

☐ Treatment in Absence ☐ Treatment in Absence

Notice of Privacy Practices

I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices (*Patients can find a copy on the Patient Info page of our website*).

Initials _____

Self-Pay Agreement

A Self-pay patient is defined as a patient who (1) has no health insurance coverage of any kind or (2) cannot provide proof of insurance (i.e., insurance ID card) at the time of service. The self-pay cost of all medical services will be collected in advance or at the time of service of office visits, diagnostic tests, and surgical procedures. Any recommended diagnostic tests or procedures (lab/blood tests, hearing tests, CT scans, ultrasounds, biopsies, etc.) have a separate cost. I understand that if I do not pay for services on the day performed, this office will bill me directly for the entire cost of those medical services.

*****If I have any questions about this policy, I have the right to speak to the Billing Department for details*****

I acknowledge that I have read the above Self-Pay Agreement, understand its terms, and agree to comply with its terms.

Initials _____

Financial Policies

I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at the time of service**. I am responsible for providing correct/updated insurance information so this medical practice can bill my insurance.

I understand that some medical services performed in the office such as hearing tests, lab tests, ultrasounds, CT scans, biopsies, endoscopies, ear cleanings, and other procedures are billed separately from the office visit.

If payment in full is not made as required, then in addition to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Peak ENT Associates or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgment). Any interest due hereunder shall be calculated at a

rate equal to 18% per annum and may, as determined by Peak ENT Associates or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily--meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.

I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Peak ENT Associates by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Peak ENT Associates or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting each and all the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy. I acknowledge that I have read, understand, and agree to the terms of the Financial Policies stated above.

Initials _____

Consent for Treatment

I voluntarily consent to medical care and examination at this medical practice and its affiliates and by its physicians, clinicians, and other personnel. I understand that the practice of medicine is not an exact science, and no guarantee has been or can be made as to the results of medical care or examinations.

Initials _____

By signing below, I agree to the terms of the initialed sections above: *Release of Medical Information, Notice of Privacy Practices, Self-Pay Agreement, Consent for Treatment, and Financial Policies.*

Signature_____ Date _____ Relation to patient_____

MEDICAL HISTORY FORM

Name:_____ Age:_____ Date of Birth: ____/____/_____ Marital Status:_____

Date symptoms started:_____ Primary reason for visit:_____

MEDICAL HISTORY *(check all that apply)*

☐ Asthma
☐ Cancer: _____
☐ Colitis
☐ Hepatitis
☐ HIV/AIDS
☐ Iritis
☐ Psoriasis
☐ Rheumatic Fever
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Uveitis
☐ Venous Thrombosis

LIST ALL DIAGNOSED MEDICAL CONDITIONS

_____
_____
_____
_____

LIST ALL HOSPITALIZATIONS AND SURGERIES:

_____
_____
_____
_____

LIST ALLERGIES TO MEDICATIONS: ☐ No Known Allergies

_____
_____
_____

Preferred Pharmacy:_____
(Name, City)

SOCIAL HISTORY *(check all that apply)*

☐ Alcohol use: _____ drinks per week ☐ No Alcohol use
☐ At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)
☐ History of drug use
Smoking Status: ☐ Current If current: ____ packs per day
☐ Former (when quit: _____) ☐ Never smoked
Second hand smoke exposure:
☐ Environmental ☐ Occupational ☐ Perinatal/before birth
☐ Tobacco use (other/chew): _____

FEMALE PATIENTS ONLY:
Number of miscarriages: _____

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU	DISEASE	RELATIONSHIP TO YOU
☐ Ankylosing Spondylitis	_____	☐ Lupus	_____
☐ Asthma	_____	☐ Osteoarthritis	_____
☐ Blood Clots	_____	☐ Osteoporosis	_____
☐ Cancer	_____	☐ Psoriasis	_____
☐ Colitis	_____	☐ Arthritis	_____
☐ Diabetes	_____	☐ Reactive Arthritis	_____
☐ Heart Disease	_____	☐ Rheumatoid Arthritis	_____
☐ Hypertension	_____	☐ Tuberculosis	_____
☐ Iritis	_____	☐ Uveitis	_____
☐ Liver Disease	_____		

LIST CURRENT MEDICATIONS & SUPPLEMENTS:

Name	**Dose**	**Frequency**	**Route** (oral, injection, etc.)

MEDICAL HISTORY FORM

Name:_____ Age:_____ Date of Birth:_____/_____/_____

REVIEW OF SYSTEMS
CHECK ALL THAT APPLY (Problems you have had within the past 3 months)

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitation or heart racing
- ☐ Swelling in legs or feet

EAR NOSE THROAT

- ☐ Dizziness
- ☐ Excessivley dry mouth
- ☐ Hoarseness
- ☐ Trouble swallowing

ENDOCRINE

- ☐ Breast discharge
- ☐ Heat or cold intolerance
- ☐ High blood sugar
- ☐ Recent weight change

EYES

- ☐ Double vision
- ☐ Dry or irritated eyes
- ☐ Loss of vision

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea or vomiting

GENERAL

- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change

INTEGUMENTARY (Skin)

- ☐ Changes in hair or nails
- ☐ Color changes with cold exposure
- ☐ New stretch marks
- ☐ Rash

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Hip pain
- ☐ Joint pain
- ☐ Muscle cramps
- ☐ Obvious visible swelling of joint

NEUROLOGIC

- ☐ Frequent headaches
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Unusual weakness in muscles

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression

RESPIRATORY

- ☐ Frequent cough
- ☐ Shortness of breath

☐ None of the above symptoms

I have reviewed the above and checked all symptoms which apply.

Patient/Representative Signature:_____ Today's Date:_____