NAME:_____ **DATE:**_____

DATE OF BIRTH:_____ **AGE:**_____ **ENT PHYSICIAN:**_____

GENDER:_____ **REFERRING PROVIDER:**_____

MARITAL STATUS: **Are you here with anyone today?**

❑ Child ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ No

OCCUPATION:_____ ❑ Yes--relationship:_____

Staff use ONLY

(Please do not write in this area)

W (lb):_____

H (in):_____

BP:_____

Pulse:_____

MEDICATIONS *List ALL the medications you are currently taking (include over-the-counter medications)*

Drug Name (Generic/Brand)	*Dosage*	*Frequency*	*Drug Name (Generic/Brand)*	*Dosage*	*Frequency*
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

ALLERGIES TO MEDICATIONS *List ALL your medication allergies*

Medication	*Reaction*	*Medication*	*Reaction*
1.		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY *List ALL your Prior Surgeries, Medical Conditions & Major Injuries*

Medical Conditions/Operations/Illnesses/Injuries	*Year*	*Doctor*	*Town/Hospital*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

SOCIAL HISTORY

Tobacco use

Have you ever smoked? ❑ Yes ❑ No

If yes, do you still smoke? ❑ Yes ❑ No ❑ Occasionally

If you quit completely, when did you quit completely? _____

How many packs per day during the time that you smoked? _____

For patients age 13 and up: Is there exposure to tobacco smoke at work? (Check no if not employed). ❑ Yes ❑ No

For patients age 12 years and younger (check at least one): Is there tobacco exposure? ❑ At home ❑ During pregnancy ❑Neither

Alcohol use

Do you drink alcohol?

❑ 6 or more drinks per day ❑ 3-6 drinks per day ❑ 1-2 drinks per day ❑ Occasionally ❑ Never

Recreational drug use

Do you use any street or recreational drugs?

❑ Daily ❑ Occasionally ❑Never **If yes, what recreational drugs do you use?** _____

FAMILY HISTORY

What runs in your family?	*Who had it?*
1.	
2.	
3.	
4.	
5.	

REVIEW OF SYSTEMS

CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY

CONSTITUTIONAL:	❑ Fever	❑ Weight loss	❑ Weight gain	
ALLERGIC:	❑ Sneezing	❑ Hayfever	❑ Nasal allergies	
EYES:	❑ Double vision	❑ Excessive tearing	❑ Itchy/watery eyes	
EARS:	❑ Ear pain ❑ Ringing/tinnitus/ unwanted noise	❑ Ear drainage ❑ Wax problems	❑ Ear infections ❑ Itchy ears	❑ Hearing loss
NOSE:	❑ Post-nasal drip/drainage ❑ Decreased smell ❑ Facial pressure	❑ Congestion ❑ Sneezing	❑ Obstruction ❑ Runny nose	❑ Bloody noses ❑ Sinusitis episodes
MOUTH:	❑ Bad breath ❑ Loss of taste	❑ Mouth sores/spots	❑ Dry Mouth	❑ Bad teeth
THROAT/NECK:	❑ Sore throat ❑ Pain on swallowing ❑ Neck pain	❑ Bad tonsils ❑ Difficulty swallowing ❑ Neck mass or lump	❑ Tonsil debris ❑ Choking	❑ Hoarseness ❑ Throat clearing
CARDIOVASCULAR:	❑ Hypertension/ High blood pressure	❑ Palpitations/ Rapid heart beat		
RESPIRATORY:	❑ Wheezing	❑ Cough		
GASTROINTESTINAL:	❑ Heartburn	❑ Vomiting	❑ Diarrhea	
GENITOURINARY:	❑ Bedwetting			
HEMATOLOGIC:	❑ Easy bruising/bleeding	❑ Taking blood thinners/ Anticoagulants	❑ Aspirin use	
ENDOCRINE:	❑ Hypothyroidism	❑ Hyperthyroidism	❑ Diabetes	
MUSCULOSKELETAL:	❑ Arthritis	❑ Fibromyalgia		
SKIN:	❑ Rash	❑ Ulcerative lesions	❑ Enlarging lesions	❑ Persistent lesions
NEUROLOGICAL:	❑ Headaches ❑ Memory loss	❑ Migraines	❑ Facial pain	❑ Dizziness
PSYCHIATRIC:	❑ Bipolar disease ❑ Anxiety	❑ Drug use	❑ Alcohol abuse	❑ Depression
SLEEP:	❑ Snoring	❑ Fatigue	❑ Sleep disturbance	

Patient Demographic Form

Please PRINT

ent MEDICAL SERVICES, P.C. ear, nose & throat care

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname**

Date of Birth | **Social Security Number** | **Gender**

Marital Status | **Not correct?** ☐Single ☐Married ☐Separated ☐Widowed ☐Life Partner ☐Divorced ☐Other | **Language other than English**

Race (Optional) | **Not correct?** ☐White-Non Hispanic ☐ Black-Non Hispanic ☐Hispanic ☐American Indian/Alaskian ☐Asian/Pacific Islander ☐Other

Home Address | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other:** _____ ☐Cell ☐Pager ☐Fax

Email Address | **Employment Status** ☐Active Duty Military ☐Child ☐Disabled ☐Employed Full-Time ☐Employed Part-Time ☐Homemaker ☐Not Employed ☐Retired ☐Self Employed ☐Student Full-Time ☐Student Part-Time ☐Other_____

Employer | **Employer Phone**

PREFERRED PHARMACY

Pharmacy | **Address**

PHYSICIAN REFERRAL INFORMATION

Primary Care Provider | **Referring Physician**

How did you hear about us? ☐Billboard ☐Employer ☐Family Member ☐Friend ☐Health Fair Event ☐Insurance ☐Magazine ☐Mail ☐News ☐Physician ☐Radio ☐Television ☐Website ☐Yellow Pages ☐Other: _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐Self (if self, skip to Emergency/Next of Kin) ☐Spouse ☐Parent ☐Other: _____

Last Name | **First Name** | **Middle Initial** | **Nickname**

Date of Birth | **Social Security Number** | **Gender**

Home Address | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other:**_____ ☐Cell ☐Pager ☐Fax

Email Address | **Employment Status** ☐Active Duty Military ☐Child ☐Disabled ☐Employed Full-Time ☐Employed Part-Time ☐Homemaker ☐Not Employed ☐Retired ☐Self Employed ☐Student Full-Time ☐Student Part-Time ☐Other_____

Employer | **Employer Phone**

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other:**_____ ☐Cell ☐Pager ☐Fax

ANY OTHER NECESSARY CONTACT INFORMATION (NOT LIVING WITH PATIENT)

Last Name | **First Name** | **Relationship to Patient**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other:** _____ ☐Cell ☐Pager ☐Fax

Patient Insurance Form

Please PRINT

Patient Name: **Patient DOB:**

PRIMARY INSURANCE		
Plan Name	**ID**	**Group No.**
Subscriber Name		**Subscriber DOB**
Subscriber Employer	**Subscriber Phone**	**Relationship to patient**

SECONDARY INSURANCE		
Plan Name	**ID**	**Group No.**
Subscriber Name		**Subscriber DOB**
Subscriber Employer	**Subscriber Phone**	**Relationship to patient**

INSURANCE RELEASE AND HIPPA PRIVACY ACKNOWLEDGEMENT INFORMATION

I HEREBY AUTHORIZE **ENT MEDICAL SERVICES, PC** TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO **ENT MEDICAL SERVICES, PC.** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I HAVE BEEN PRESENTED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES, DETAILING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW AND OUTLINING MY RIGHTS REGARDING MY HEALTH INFORMATION.

PATIENT SIGNATURE:_____ **DATE:** _____

Thomas F. Viner, MD
Thomas A. Simpson, MD
Dwayne T. Capper, MD
Jeremy D. Vos, MD
Daniel R. Olney, MD
Michael J. Reed, MD

HIPAA Release Form

Who may we release your information to?

Patient Name: **Date of Birth:**

☐ **I do not authorize ENT Medical Services, PC, to share my medical or financial information with anyone. Please sign and date below.**

☐ **I authorize ENT Medical Services, PC, to share my information with the following individual(s):**

Person #1

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #2

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #3

Name (Please print):

_____

Relationship to patient: _____ Phone #: _____

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

STATEMENT OF CONSENT

I am aware that I may withdraw my consent at any time except to the extent that action has been taken in reliance on this statement of consent.

X_____ _____

Signature of Patient or Patient's Guardian/Representative Date

_____

If signed by Patient's Guardian/Representative, please print name and relationship to patient

ENT Medical Services, PC
2615 Northgate Drive
Iowa City, IA 52245

Thomas F. Viner, M.D.
Thomas A. Simpson, M.D.
Dwayne T. Capper, M.D.
Jeremy D. Vos, M.D.
Daniel R. Olney, M.D.
Michael J. Reed, M.D.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION

TODAY'S DATE:_____

NAME OF BENEFICIARY **HIC NUMBER**

I request that payment of authorized Medicare benefits be made either to me on my behalf or to **ENT Medical Services, PC** for any services furnished by **ENT Medical Services, PC.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

Financial Policy

ENT Medical Services, PC
2615 Northgate Drive
Iowa City, IA 52245
P (319) 351-5680 F (319) 351-8980

This agreement is between ENT Medical Services, P.C. as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

IT IS YOUR RESPONSIBILITY TO KNOW THE REQUIREMENTS OF YOUR INSURANCE COMPANY. THIS INCLUDES PARTICIPATION, IN NETWORK, OUT OF NETWORK, REFERRAL REQUIREMENTS, SECOND OPINION, PRIOR APPROVAL, PRE-CERTIFICATION AND OUTPATIENT AND / OR INPATIENT STATUS. YOU ARE ALSO RESPONSIBLE FOR ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLE REQUIRED BY YOUR INSURANCE PLAN. YOU MUST BE AWARE OF ANY PRE-EXISTING CONDITIONS, WAIVERS OR WAITING PERIODS, OUTLINED BY YOUR INSURANCE CARRIER.

MONTHLY STATEMENTS: If you have a balance on your account, you will receive a monthly statement. It will show your current balance, insurance adjustments/payments and monthly interest on balances over 60 days. Unless other arrangements are approved by ENT Medical Services, P.C., in writing, the balance on your account is due, in full, and payable within 60 days from the date of service.

INSURANCE CLAIMS: We will gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services.

SURGICAL PROCEDURES: Twenty-five percent (25%) of your insurance deductible is due prior to all surgical procedures.

CO-PAY: Co-payments are due at the time of service. Your contract with your insurance company requires that you pay all applicable co-payments and deductibles. Failure to comply could lead to loss of insurance coverage.

DIVORCE: In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

WORKERS COMPENSATION: We require written approval or authorization by your employer and/or Worker's Compensation carrier PRIOR to your initial visit. If your claim is denied, you are responsible for payment in full.

MONTHLY PAYMENT OPTIONS

Automatic withdrawal from your checking/savings account ON BALANCES OVER $300 without interest. We will include a service fee for all rejected withdrawals due to insufficient funds.

Financial Policy

Cash, check, credit card or money order with interest of 1.5% monthly or 18% annually. This excludes all USA government-sponsored payers: i.e., Medicare, Title 19 and Tricare.

In addition, you may use CareCredit®. Please contact our insurance department regarding this product. Literature is available upon request in our reception area.

UNINSURED PAYMENT OPTIONS: Payment is required in full to the date of service unless other arrangements have been made, in writing, with ENT Medical Services, P.C. A 20% discount will be taken if the balance is paid in full on the date of service.

EXTENSIVE PAYMENT AND/OR LARGE BALANCES: We understand that medical bills can add up quickly and you may not be able to pay the balance in full within 60 days. We would suggest securing a bank loan for balances over $1000.00 if necessary, as we are unable to extend credit for long periods of time.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt by means of a collection agency or an attorney.

MONTHLY PAYMENT SCHEDULE FOR PAYMENT BALANCE

$ 0 - $50	Payment in Full
$ 50 - $150	2 Monthly Payments
$150-$300	3 Monthly Payments
$300-$500	4 Monthly Payments
$500-$1000	6 Monthly Payments
$1000-$3000	12 Monthly Payments
$3000-$5000	18 Monthly Payments
$5000-above	24 Monthly Payments

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

Effective Date: Once you sign this agreement, you agree to all of the terms and conditions herein and this agreement will be in full force and effect.

Patient Name: _____ Date: _____

Patient Signature: _____

Responsible Party (If not the patient): _____

Co-Signature (if required): _____