PT ID# _____ **Patient Intake Form**

First Name _____ M. I. ____ Last Name _____ Age _____ Sex ☐ M ☐ F

SS# _____ Date of Birth _____ Phone # _____

Marital Status: _____ Cell # _____

Address _____

City _____ State _____ Zip _____

Occupation: _____ Employer: _____

E-mail Address: _____ DL #: _____

Referred by: _____ *PCP: _____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ E-mail *PCP Phone #: _____

Pharmacy Information

Name: _____ Phone # _____

Address: _____

City: _____ State _____ Zip _____

Authorization to share information with other health care providers involved in your care and have medication history pulled from your insurance company.* ☐ Yes ☐ No

* by checking "No" I understand AENT will not disclose my medical health records with my insurance company, which could result in denial of payment and I will be financially responsible.

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report

Insurance Information: Primary Insured SSN # _____ Relation to Patient _____

Primary: _____ Insured: _____ Insured's DOB _____

Claims Address: _____

Phone #: _____

Policy #: _____ Group #: _____

Secondary: _____ Insured: _____ Insured's DOB _____

Claims Address: _____ Primary Ins. SSN# _____

Phone #: _____

Policy #: _____ Group #: _____

Emergency Contact: _____ Phone #: _____

Signature: _____ **Date:** _____

Name: _____ DOB: _____ Date: _____

Please describe the problem or symptom(s) for which you are being seen for today: _____

_____

_____

_____

How long have you had this problem? _____

What medications have you tried for this problem? _____

_____ Did they help? _____

What makes the problem or symptom(s) worse? _____

What makes the problem or symptoms(s) better? _____

Any other associated symptoms with the problem? _____

_____

If you have pain:

Rate it on a scale of 1-10 (1 being slight & 10 be severe): _____

Constant or Intermittent: _____

Describe the pain: _____

_____

Reviewed by: _____

Medical History Questionnaire

PAST MEDICAL HISTORY

Check if you've ever had:

- ☐ **No Active Problems**
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ Heart Disease
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Seizure or Epilepsy
- ☐ Recurrent Bacterial Infections
- ☐ Stroke or TIA
- ☐ Thyroid Disorder
- ☐ Other _____

PAST SURGICAL HISTORY (If Applicable)

Check if you've ever had:

- ☐ Appendectomy
- ☐ Back
- ☐ Breast
- ☐ Bypass
- ☐ D&C
- ☐ Gallbladder
- ☐ Sinus Surgery
- ☐ Septoplasty
- ☐ Turb Reduction
- ☐ Ear Tube
- ☐ Ear Surgery
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Tonsils/ Adenoids
- ☐ Tubal Ligation
- ☐ Other: _____

Family History: Please list any significant health problems in you immediate family. ☐ No Significant Family History ☐ Adopted

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease/Enlarged Heart
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Social History

Drink Alcohol? ☐ No ☐ Daily ☐ Somedays ☐ Former ☐ Socially

History of Substance Abuse ☐ Yes ☐ No

Tobacco Use? ☐ Smoking cigarettes ☐ Secondhand Smoke in home ☐ Previous History of smoking ☐ Never a smoker

First Name:	Last Name:	Sex:	DOB:	DOS:	Physician:	MRN:

List any Drug/Medication Allergies

ALLERGIES to Medications / Food / Contacts (Describe Reaction)

1. _____
2. _____
3. _____
4. _____
5. _____

____ **No Known Drug Allergies**

List any current medications, health supplements and homeopathic treatments: ____ NONE

	Medication Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

REVIEW OF SYSTEMS (Do you now or have you had within the past year any of the problems below)

Constitutional ☐ **All Negative**

☐ Y ☐ N Chills ☐ Y ☐ N Fever ☐ Y ☐ N Recent Wt Gain (___ Lbs)

☐ Y ☐ N Feeling Tired ☐ Y ☐ N Recent Wt Loss (___ Lbs)

Eyes ☐ **All Negative**

☐ Y ☐ N Discharge from Eyes ☐ Y ☐ N Eye Pain ☐ Y ☐ N Eyes Itch

☐ Y ☐ N Dry Eyes ☐ Y ☐ N Eyesight Problems ☐ Y ☐ N RedEyes

Ear/Nose/Throat ☐ **All Negative**

☐ Y ☐ N Earache ☐ Y ☐ N Nasal Discharge ☐ Y ☐ N Sore Throat

☐ Y ☐ N Hoarseness ☐ Y ☐ N Neck Pain ☐ Y ☐ N Trouble Swallowing

☐ Y ☐ N Fluid in Ears ☐ Y ☐ N Nosebleeds ☐ Y ☐ N Sinus / Facial Pain

☐ Y ☐ N Loss of Hearing ☐ Y ☐ N Ringing in the Ears ☐ Y ☐ N Nasal Congestion

Cardiovascular ☐ **All Negative**

☐ Y ☐ N Chest Pain ☐ Y ☐ N Heartburn ☐ Y ☐ N Leg or Arm Pain

☐ Y ☐ N Chest Tightness/Heaviness ☐ Y ☐ N High Blood Pressure ☐ Y ☐ N Leg or Arm Swelling

Respiratory ☐ **All Negative**

☐ Y ☐ N Cough ☐ Y ☐ N Short of Breath ☐ Y ☐ N Wheezing

Gastrointestinal ☐ **All Negative**

☐ Y ☐ N Abdominal Pain ☐ Y ☐ N Constipation ☐ Y ☐ N Nausea

☐ Y ☐ N Blood in Stool ☐ Y ☐ N Diarrhea ☐ Y ☐ N Vomiting

Genitourinary ☐ **All Negative**

☐ Y ☐ N Frequent Bladder Infections ☐ Y ☐ N Blood In The Urine

Musculoskeletal ☐ **All Negative**

☐ Y ☐ N Back Pain ☐ Y ☐ N Bone Pain ☐ Y ☐ N Joint Pain

Integumentary ☐ **All Negative**

☐ Y ☐ N Skin Rash ☐ Y ☐ N Itching ☐ Y ☐ N Breast Pain

☐ Y ☐ N Skin Bruising ☐ Y ☐ N Skin Wound ☐ Y ☐ N Breast Lump

Neurological ☐ **All Negative**

☐ Y ☐ N Anxiety ☐ Y ☐ N Double Vision ☐ Y ☐ N Syncope/Fainting

☐ Y ☐ N Blurred Vision ☐ Y ☐ N Headaches ☐ Y ☐ N Vision Loss

☐ Y ☐ N Depression ☐ Y ☐ N Memory Loss ☐ Y ☐ N Weakness in Extremities

☐ Y ☐ N Dizziness ☐ Y ☐ N Seizure

Allergy, Ear, Nose & Throat Center, Ltd
Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To Public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for the intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Rights Regarding Your Health Information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, and billing records, but *not* including psychotherapy notes. You must submit your request in writing to: Allergy, EN&T Center Ltd, Medical Records Dept. 7245 E. Osborn Rd. Ste. 1, Scottsdale, AZ 85251

Your Rights Regarding Your Health Information (Continued)

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to: Allergy, EN&T Center Ltd. Attn: Office Manager, 7245 E. Osborn Rd, Ste. 1, Scottsdale, AZ 85251. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of this notice, contact any Front Office Receptionist at Allergy, EN&T Center Ltd. 7245 E. Osborn Rd. Ste. 1, Scottsdale, AZ 85251, or call (480) 994-0308.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Allergy, EN&T Center Ltd. Attn: Office Manager, 7245 E. Osborn Rd. Ste. 1, Scottsdale, AZ 85251. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact: Allergy, EN&T Center, Attn: Office Manager 7245 E. Osborn Rd #1, Scottsdale, AZ 85251 or call (480) 994-0308 for further information.

I hereby acknowledge that I have been presented with a copy of Allergy, Ear, Nose & Throat Center's Notice of Privacy Practice.

_____

Signature

_____

Printed Name

_____

Date

_____ **In the event of returning my phone call regarding any inquiries I may have in the future, I authorize Allergy, EN&T Center staff members to leave a detailed voicemail if I am unable to take their phone call.**

_____ **In the event of returning my phone call regarding any inquiries I may have in the future, I *DO NOT* authorize Allergy, EN&T Center staff members to leave a detailed voicemail if I am unable to take their phone call.**

Allergy, Ear, Nose
& Throat Center, Ltd.

EN&T

FINANCIAL POLICY

Verification of coverage cannot be made at the time of your appointment. If your insurance company denies payment for any *reason, you will be responsible for the entire amount due.*

It is your responsibility, as a patient, to know your insurance benefits. If you are unsure of your benefits, please call the number on the back of your insurance card.

We accept **Cash, Check and Credit Cards.** Any returned checks will constitute a $50 fee.

It is the Account Holder's responsibility to pay the remaining balance that is not covered by insurance. **Payment in full is due upon receipt of your statement.**

If treatment is rendered on a minor child, the parent or guardian who accompanies the child to the appointment and signs the policy, is financially responsible for the amount due.

When rescheduling or cancelling an In-Office Procedure/Testing or a Surgery, a 72 hour notice is required. Failure to contact our office prior to the 72 hour notice will result in a $100 fee.

If this account should be referred to a collection agency, I will be responsible for an additional collection fee of 43% on the total amount due, and all legal fees incurred to obtain payment.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.
I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above. _____**(Please Initial)**

I have read and understand Allergy, Ear, Nose & Throat Center office financial policies.

Patient Name:_____ Date:_____

Responsible Party Signature:_____ Date:_____

7245 E. Osborn Road, Suite 1, Scottsdale, AZ 85251 · 480-994-0308 · Fax 480-941-3710

Allergy, Ear, Nose & Throat Center, PLLC

EN&T

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name First MI Last Date of Birth SSN

I authorize: Allergy, Ear, Nose & Throat Center, PLLC
Organization/Agency

7245 E Osborn Rd Suite 1 Scottsdale AZ 85054
Address City State Zip Code

to release information from my medical record to: _____
Organization/Agency

_____
Address City State Zip Code

Purpose for disclosure: _____

The type of information to be disclosed includes:

- ☐ Progress Notes
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Ancillary Reports (Lab, X-ray, EKG, etc.)
- ☐ Verbal Communication
- ☐ Other _____

If applicable, the undersigned further authorizes Allergy, Ear, Nose & Throat Center, PLLC to disclose a copy of Record pertaining to:

1. Testing and/or treatment for AIDS and AIDS related diseases
2. Treatment for psychiatric illness
3. Treatment for drug/alcohol abuse

This authorization shall be considered invalid after 60 days. I may revoke this authorization at any time by providing Allergy, Ear, Nose & Throat Center, PLLC written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

_____
Signature of Patient or Legal Guardian Date

NOTE: In case a patient is physically unable to sign this authorization, he/she should place and "X" on the signature line and have his/her assent witnessed.

Allergy, Ear, Nose
& Throat Center, Ltd.
EN&T

JOEL G. COHEN, M.D., F.A.C.S.
BRIAN G. LEE, M.D.

7245 E. Osborn Road
Suite 1
Scottsdale, AZ 85251
480-994-0308

www.joelcohenmd.com
www.Scottsdale-ENT.com
Fax 480-941-3740

Do you authorize our staff to leave a message on your answering machine or voice mail regarding your test or exam results, appointments, billing information or medication refill? Please initial.

YES _____ NO _____

Please list any names that you authorize to speak with our staff regarding your medical or billing information.

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

If you would like to authorize anyone else, please list below.

Patient Signature (Guardian): _____

Print Name: _____ Date: _____