

1 ABOUT THE PATIENT

Today's Date _____

Patient Name _____

Home Address _____
NO P.O BOXES Apt/Condo #

City _____ State _____ Zip _____

Birth Date _____ Age _____

M F Ethnicity (Race) _____
(FOR LAB WORK PURPOSES)

Social Security # _____
(Required even if the patient is a minor, for hospital registration)

Single Married Divorced Widowed Separated

Home # _____ Cell/Pgr # _____

Work # _____ Ext. _____

Employer _____

Where & when are the best times to reach you? _____

2 PRIVACY QUESTIONS

Do we have permission to call you at home? Y N

May we leave a message at your home with other residents? Y N N/A

To whom at your home may we talk about your medical info?
 His/Her name _____

Relationship _____ Phone # _____

May we leave a message at home on your answering machine or voice mail? Y N N/A

Do we have permission to call you at work? Y N N/A

May we leave a message on your voice mail at work? Y N N/A

May we leave a message at work requesting **only** that you return our call? Y N N/A

Emergency Contact (Neighbor or Relative not living w/ you)

His/Her name _____

Relationship _____ Work # _____

Home # _____ Cell/Pgr # _____

3 PRIMARY INSURANCE

Insurance Co. Name _____

Insured's Name _____

Insured's D.O.B. _____ ID# _____

Group # _____ Employer _____

Patient Relationship to Insured Self Spouse Dependent

SECONDARY INSURANCE

Insurance Co. Name _____

Insured's Name _____

Insured's D.O.B. _____ ID# _____

Group # _____ Employer _____

Patient Relationship to Insured Self Spouse Dependent

4 FOR MINORS ONLY

Child lives with Both Parents Mother Father

Mother/Guardian _____

Addr (if different) _____

D.O.B. _____ Social Security # _____

Home # _____ Cell/Pgr # _____

Work # _____ Ext. _____ Employer _____

Father/Guardian _____

Addr (if different) _____

D.O.B. _____ Social Security # _____

Home # _____ Cell/Pgr # _____

Work # _____ Ext. _____ Employer _____

5 PERSONAL PHYSICIAN INFORMATION

May we provide your physician with information regarding your visit? Y N

Physician's Name _____

Addr _____

City _____ State _____ Zip _____ Phone # _____

If you have another physician involved with your care and would like info sent to him/her, please list below

Physician's Name _____

Addr _____

City _____ State _____ Zip _____ Phone # _____

CENTRAL OHIO EAR, NOSE AND THROAT, INC.

Privacy Consent for the Use and Disclosure of your Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Central Ohio Ear, Nose and Throat, Inc. to use and disclose my protected health information for the purposes of my health care treatment and for payment and operations of this practice.

Consent for treatment: I, with my signature, authorize Central Ohio Ear, Nose and Throat, Inc., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person, if I am the legal guardian) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for continuity of care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Notice of Privacy Practices.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent related to the Notice of Privacy Practices: I have had a chance to review the Notices of Privacy Practices as part of this registration process. I understand that the terms of the Notice of Privacy Practices may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to restrict how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations, but this practice is not required to agree to my restrictions with regards to these activities. However, if the practice does agree to my restrictions on how my information is disclosed, it is bound by that agreement.

I understand that this practice can refuse me services if I refuse to sign or alter this consent. I may revoke this consent at any time, but this practice can refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Parent/Legal Guardian Signature _____ Date _____

Patient Name printed _____ Relationship to patient _____

Patient unable to sign Notice of Privacy Practices due to: _____

Revocation:

I hereby revoke the consent given above:

Patient/Parent/Legal Guardian Signature _____ Date _____

Patient Name printed _____ Relationship to patient _____

Office Use Only

**The Notice of Privacy Practices signed by and copy give to the Patient/Parent/Legal Guardian on _____
Office Staff Initials _____**

PATIENT MEDICAL HISTORY/QUESTIONNAIRE

Please return this form with your new patient forms or bring it with you on the day of your appointment.

Patient Name: _____ Date of Birth: ____/____/____ Date Completed: ____/____/____

MEDICATION ALLERGIES: Yes No **If "yes", is the patient allergic to the following? Check the "yes" or "no" box for all items. A response is necessary for each item.**

	YES	NO		YES	NO		YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Dye	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Tape	<input type="checkbox"/>	<input type="checkbox"/>

Other medication allergies not listed above: _____

Please list all current medications including dosage and times per day. Include over-the-counter medication as well as vitamins and herbs.

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list any surgeries and/or hospitalizations with approximate dates and reason admitted.

SURGERIES/HOSPITALIZATIONS	YEAR	SURGERIES/HOSPITALIZATIONS	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ANESTHESIA PROBLEMS: YES NO **IF YES, PLEASE EXPLAIN:** _____

PATIENT PAST MEDICAL HISTORY Has the patient ever had the following? **Check the "yes" or "no" box for all items.** For "yes" answers, please explain. **A response is necessary for each item.**

	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Metal Rods/Pins/Implants	<input type="checkbox"/>	<input type="checkbox"/>
HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical Problems explained here: _____

PATIENT SOCIAL HISTORY **Some areas may apply to minors. Please read and answer carefully.**

Marital status: Single Married Separated Divorced Widowed

Occupation: _____

Does the patient drink alcohol?

- Child, does not apply
- No, never or rarely
- No, but I have previously
- Yes, daily
- Yes, 1 or more times per week
- Yes, 1 or more times per month

Does the patient smoke?

- Child, does not apply
- No, never smoked
- No, quit smoking _____ years ago.
- At the time the patient was smoking _____ pack(s) per day for _____ years.
- Yes, smoke _____ pack(s) of cigarettes per day for _____ years.
- Yes, smoke cigarettes occasionally, but not everyday
- Yes, smoke cigars or a pipe

Caffeine Intake? (Type/Frequency): _____ per day.

Exercise? Yes No Type/Frequency: _____

Exposure to excessive noise? Yes No Type/Frequency: _____

Does the patient use recreational or illegal drugs?

- No
- No, but in the past. Type/Frequency: _____
- Yes, presently. Type/Frequency: _____

PATIENT MEDICAL HISTORY/QUESTIONNAIRE CONT.

Patient Name: _____ **Date of Birth:** ____/____/____ **Date Completed:** ____/____/____

PATIENT FAMILY HISTORY Has any **blood relative** had any of the following? Check the "yes" or "no" box for all items. For "yes" answers indicate which relative has/had the problem. **A response is necessary for each item.**

	YES	NO	RELATIONSHIP
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS Please check the "yes" or "no" box if you presently have any of the following problems. **A response is necessary for each item.**

		YES	NO		YES	NO
GENERAL	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss <input type="checkbox"/> gain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Injury/Trauma to eyes	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Chronic headache	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	Manic/Depression	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Skin lesion(s)	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
GI	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYMPH	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>
	Ear pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus/Ear noises	<input type="checkbox"/>	<input type="checkbox"/>
	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (spinning)	<input type="checkbox"/>	<input type="checkbox"/>
	Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
	Facial numbness	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____/_____/_____
 Signature of **Patient, Parent or Legal Guardian** Date

I have reviewed the questionnaire with the patient.

_____/_____/_____
 Signature of **Physician** upon review Date

Clifton R. Hood D.O. J. Paul Burkhart, D.O. Timothy R. Budnik, D.O.

CENTRAL OHIO EAR, NOSE AND THROAT, INC.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information in this practice. New federal legislation (HIPAA) requires that we issue this official notice of our privacy practices. This practice has an obligation to maintain all medical information in the strictest confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as PHI or protected health information. This policy requires that you, the patient, specify at the time of registration with this practice how we can release your information. You can change these specifications at any time with either written or verbal notification, followed up in writing. Changes can only impact your care or information from that point in time forward.

How We May Use and Disclose Medical Information about You with Your Consent.

- For treatment. We may use your PHI to provide you with medical treatment or services in this practice or other locations under our immediate care. This may include medical assessment, diagnostic testing and procedures. This includes coordination of care with other physicians involved with your care, referrals and related care needs such as home care agencies, hospice, surgery centers, hospitals, and diagnostic testing centers needed by you during the course of your care.
- For obtaining payment. We may disclose your PHI to your identified health care program to obtain payment for treatment. This would include any documentation related to this care, including history forms, progress notes, test results and procedure notes. This would include eligibility verification, prior authorization and claim submission
- For health care operations. We may disclose your PHI for health care operations such as enrolling with insurance programs, hospital privileges, Quality Care Programs and compliance with federal and state laws and regulations.
- For appointment reminders and health-related benefit services **only** with your consent identified on the registration form.
- For disclosure to your family and friends concerning any related health care information **only** with your consent on the registration form which can be modified at any time orally, followed by written notification.
- **Consent is not required for emergency care and treatment.** An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

How We May Use and Disclose Your Medical Information Without Your Consent.

- Disclosure required by government or law enforcement agencies, legal proceedings and other disclosures required by law. Examples would include police investigations, FDA requests, domestic violence or neglect situations, military records request, and to a correctional institute for inmate care.
- Information used for public health purposes, medical examiners or for purposes related to a person's death or for the health department for disease tracking, i.e. Tumor Board.
- To avoid harm. In order to avoid a serious threat to the health and safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- Information used for health care oversight, such as a site review by an insurance company.

- Workers' compensation or employee paid claims or similar programs for processing of claims.
- To other health care providers and covered entities for treatment, payment or health care operations as permitted by HIPAA.

Your Individual Rights Regarding Your Medical Information.

- Authorizations. All other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose your PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided to you.
- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of your PHI, but there will be copying and postage fees to cover labor and supply costs.
- The right to an accounting of non-standard disclosures we have made with your PHI.
- The right to correct your file through an amendment process if appropriate.

This practice reserves the right to modify or change this Notice and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retro-actively to the initial date of the Notice. An updated Notice will be posted in the office within 60 days of the revision.

If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Office Manager in our business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto. These entities only accept written correspondence.

Office of Civil Rights-Regional Manager
 Department of Health & Human Services
 233 N. Michigan Ave., Suite 240
 Chicago, IL 60601

Palmetto GBA
 Part B Operations-HIPAA Compliance Concerns
 PO Box 18957
 Columbus, OH 43218

Patient Name Printed _____ DOB _____

Patient/Parent/Legal Guardian Signature
 on Receipt of Privacy Notice _____ Date _____

Patient Unable to sign due to _____ Refused to sign Date _____