East Tennessee
Ear, Nose, Throat & Allergy
SPECIALISTS

Dear Patient:

Welcome to East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC! We appreciate the opportunity to care for you and your family.

In order to serve you more efficiently, we need your help with the enclosed new patient paperwork. Please complete all forms and return them when you come for your appointment on _____at _____.

Things to bring to your appointment:

1. All insurance cards and if your insurance requires a referral, please make sure we have received it before your appointment.
2. Driver's License or Photo ID.
3. The completed new patient paperwork.
4. Any co-payment or co-insurance your insurance company requires you to pay. These amounts will be collected at the time of your appointment.
5. Any X-rays (actual films and reports), CT scans (actual films/DVD and reports), and any other test results relating to your current problem/s.
6. A list of your current medications and any medications you are allergic to.
7. If the patient is under 18, they must be accompanied by a parent or legal guardian WITH legal guardianship documents.

If your child is 2 years or younger and coming in for hearing, please make sure your appointment is around your child's nap time. It is easier to get a more accurate hearing test if the child is asleep.

Please call our office and cancel if you are unable to keep your appointment. We have a 24-hour cancellation policy that all no shows will be billed $25.00 if we are not notified 24 hours prior to the appointment.

Thank you.

East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC

Charles G. Sewall, M.D. **Brynae L. Miley, M.D.** **Vivian Mandas, PA-C** **Caitlin Prusha, PA-C**

Date: **Appointment Time:** **Arrival Time:**

Patient Name: _____ Date of Birth: _____
Last First MI

Social Security Number: _____ Gender: _____Female _____ Male

Language:_____ Race:_____ Ethnicity:_____

Address: _____
Street Apt. # City State Zip Code

Phone Number: (____) _____ (____) _____ (____) _____
Home Work Cell Phone/Pager

Email: _____ Marital Status: ☐M ☐W ☐S ☐D

Emergency Contact Name:_____ Phone Number:_____

Patient's Employer: _____

How did you hear about our office? (please check one) Dr. referral _____ Website ☐

Newspaper ☐ FB/Instagram ☐ Friend/Family member ☐ Close to home/work ☐ Yellow Pages ☐

Name of Insurance Company: _____*please give insurance cards to receptionist to make copies

Name of Policyholder: _____ Relationship to Patient: _____

Policyholder's Social Security Number: _____ Policyholder's Birthdate: _____

Policyholder's Employer: _____ Phone number: _____

Name of Secondary Insurance Co:_____ Name of Policyholder:_____

Policyholder's SSN:_____Policyholder's Birthdate:_____ Relationship to Patient:_____

Complete below ONLY *if 18 years and younger*

Mother's Name: _____ Mother's Date of Birth: _____
Last First MI

Mother's Address if different from patient: _____
Street Apt. # City State Zip Code

Mother's Phone Number: (____) _____ (____) _____ (____) _____
Home Work Cell Phone/Pager

Mother's Social Security Number: _____ Mother's Employer: _____

Father's Name: _____ Father's Date of Birth: _____
Last First MI

Father's Address if different from patient: _____
Street Apt. # City State Zip Code

Father's Phone Number:(_____)_____ (_____) _____ (_____)_____
Home Work Cell Phone/Pager

Father's Social Security Number: _____ Father's Employer: _____

East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC

Consent to the Use and Disclosure of Health Information

Name_____ DOB_____

Our Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

I authorize my medical information to be discussed/disclosed to:

☐ **Family member or friend_____** ☐ **Physician _____**
FULL NAME **FULL NAME**

☐ **Other_____**
FULL NAME

Detailed messages regarding test results and appointment reminders can be left on answering machine or voicemail:

☐ **Yes** **Please list Phone #_____** ☐ **No**

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC

_____ _____
Signature of Patient or Legal Representative Date

East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC

PATIENT HEALTH HISTORY FORM

Today's Date: _____

Patient's Name: _____ DOB: _____ ☐ Male ☐ Female

Person Completing this form: ☐ *Patient* ☐ *Mother* ☐ *Father* ☐ *Other*_____

MEDICAL INFORMATION: Reason for seeing the doctor: _____
Height: _____ *Weight:* _____ *Pharmacy and location:*_____

MEDICATIONS: Please list any prescription, over-the-counter or herbal medications that you are currently taking.

Name of Medication	Strength (mg, etc)	Dose (how much/day)	Reason for taking medication

ARE YOU ALLERGIC to *ANY MEDICATION*? ☐ **N** ☐ **Y** If yes, please list below.

Name of Medication	Type of reaction (nausea, hives, etc.)

NON - MEDICATION ALLERGIES- Please circle any of the following that you are **ALLERGIC** to:

☐ **Adhesive tape** ☐ **Metal** ☐ **None**
☐ **Iodine** ☐ **Seafood**
☐ **Latex** ☐ **Contrast Dye**

PAST HEALTH: Please check if you have ever been ***DIAGNOSED*** with any of the following:

☐ **Breast Cancer** ☐ **Migraine Headaches** ☐ **High Cholesterol** ☐ **Tuberculosis** ☐ **Stroke** ☐ **Hemophilia**
☐ **Lung Cancer** ☐ **Cataracts** ☐ **Heart Attack** ☐ **Hepatitis** ☐ **Anxiety** ☐ **HIV**
☐ **Skin Cancer** ☐ **Glaucoma** ☐ **High Blood** ☐ **Gastrointestinal**
☐ **Throat Cancer** ☐ **Nasal Allergies** ☐ **Pressure** ☐ **Reflux** ☐ **Depression**
☐ **Prostate Cancer** ☐ **Sleep Apnea** ☐ **Asthma** ☐ **Stomach Ulcer** ☐ **Diabetes**
☐ **Other Cancer** ☐ **Blood Clots/DVT** ☐ **Chronic** ☐ **Prostate** ☐ **Thyroid**
☐ **Bronchitis** ☐ **Enlargement** ☐ **Dysfunction**
☐ **Emphysema** ☐ **Renal Failure** ☐ **Anemia**

(For Women) Are you Pregnant? ☐ ***N*** ☐ ***Y***

SURGERIES AND HOSPITALIZATIONS: Have you ever had any problems with ***ANESTHESIA?*** ☐ **N** ☐ **Y**
If yes, please list what sort of **problems**: _____

Please list any ***surgeries*** you have had and the date of the surgery.

_____
_____

Have you been HOSPITALIZED for a MEDICAL ILLNESS? ☐ **N** ☐ **Y** If yes, list hospitalizations, the reason for admission, and the approximate date(s) of admission_____
_____

List any illnesses or past medical history not already listed:_____
_____

Are you under pain management or a pain contract with any facility?_____Yes_____No. If yes, what facility_____

If you are **50** or over, have you had a colonoscopy? ☐ **Yes** If so, **Month**_____ **Year**_____ ☐ **No**
If you are **65** or over, have had a Pneumonia Vaccine? ☐ **Yes** If so**, Month** _____ **Year** _____ ☐ **No**

FAMILY HISTORY: Has anyone in your immediate family had any of the following problems? Please check any box that applies.

	Mother	Father	Brother	Sister	Child		Mother	Father	Brother	Sister	Child
Slow to wake up from anesthesia	☐	☐	☐	☐	☐	Lung Cancer	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐	☐
Chronic Sinus Disease	☐	☐	☐	☐	☐	Bleeding/clotting problems	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	**NONE**	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐						

SOCIAL HISTORY
Are you retired ☐ **N** ☐ **Y**? What is or was your occupation? _____

Have you ever used tobacco in any form? ☐ **N** ☐ **Y** If yes, please complete the following:

Type of Tobacco:	From year:	To year:
Cigarettes per day:		
Other: (list type)		

Have you ever used alcohol in any form? ☐ **N** ☐ **Y** If yes, please complete the following:

Type of Alcohol:	From year:	To year
Beers per week:		
Wine glasses per week:		
Other: (list type)		

Are you exposed to second-hand smoke? ☐ **N** ☐ **Y**

REVIEW OF SYSTEMS: Please check any of the following that you now have or have recently had:

- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ Unintentional Weight loss
- ☐ Unintentional Weight gain
- ☐ Dizziness
- ☐ Frequent Headache
- ☐ Severe face pain
- ☐ Blurred Vision
- ☐ Itchy eyes
- ☐ Loss of Vision
- ☐ Painful eye
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ringing in ears
- ☐ Nasal Congestion
- ☐ Frequent Nosebleeds
- ☐ Post-nasal drainage
- ☐ Belching sour material into throat
- ☐ Hoarseness or other voice change
- ☐ Mouth Ulcer
- ☐ Partials or dentures
- ☐ Blacking out or fainting
- ☐ Chest pain
- ☐ Heart Murmur
- ☐ Irregular Heartbeats
- ☐ Leg cramps
- ☐ Swelling of ankles
- ☐ Frequent non-Productive cough
- ☐ Frequent Productive cough
- ☐ Stiffness in Joints
- ☐ Swelling of joints
- ☐ Change in sense of smell
- ☐ Change in sense of taste
- ☐ Seizures
- ☐ Tremor
- ☐ Appetite is increased
- ☐ Cold Feeling
- ☐ Bleed excessively after injury
- ☐ Bruise easily
- ☐ Masses (lumps) in armpits
- ☐ Masses (lumps) in neck
- ☐ Masses (lumps) in groin
- ☐ Hives
- ☐ Sneezing

For Office Use Only

Reviewed by Dr.:_____
Date: _____
Extracted to AllMeds by: _____

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I hereby authorize my insurance benefits to be paid directly to East Tennessee Ear, Nose, Throat, & Allergy Specialists, PC ("ETENTS") realizing I am responsible to pay non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers and/or other consulting physicians or facilities who may require it.

I understand that I am responsible for giving ETENTS my correct insurance information, primary and secondary coverages, and understand that I will be held responsible for unpaid allowables if I supply incorrect information.

I agree to be responsible for any reasonable collection costs (balance due plus 30%) and/or attorney fees incurred in collecting a delinquent account. Interest will not be charged on the outstanding balance. (This disclosure is in compliance with the Truth-In-Lending Act).

I understand that the physicians of ETENTS perform most procedures at Advanced Family Surgery Center and that some of the ETENTS physicians have an ownership interest in the Surgery Center. I understand I may have the same procedure performed at an alternate facility that is not in any way connected, financially or otherwise, to the referring physician or his or her practice. The alternate facilities are Methodist Medical Center, Baptist Health Corbin, East Tennessee Children's Hospital and Children's West Surgery Center.

Patient Name:_____ DOB:_____
Print

Signed:_____ Date:_____

FOR MINORS ONLY: I, _____ hereby state that I am the □ biological parent □ legal guardian □ other (specify)_____ of the patient and am authorized to sign on their behalf. I understand that if I am not the biological parent that I must provide legal documentation.