CURRENT PROBLEM AND PAST MEDICAL AND SOCIAL HISTORY FORM

Please return completed form to the front desk. NO PENCIL PLEASE. Thank you.

NAME _____
(last) (first) (middle initial)

ADDRESS _____
_____
_____

E-Mail _____
(use of email internal only may use to give office updates)

PERMITTED TO DISCLOSE MEDICAL INFORMATION TO:

____SPOUSE ____ PARENT ____CHILD (OVER 18)

OTHER _____

COMMENTS _____
_____
(Permission given per electronic signature)

SOCIAL SECURITY NO._____
(last 4 digits)

DATE OF BIRTH_____

RACE: White (please circle)
Black/African American
American Indian/Alaska Native
Asian
Native Hawaiian/Other Pacific Islander
Unknown

ETHNICITY: Spanish/Hispanic Origin (please circle)
Not of Spanish/Hispanic Origin
Unknown

LANGUAGE_____

TELEPHONE (home) _____
(work) _____
(cell) _____

REFERRING DOCTOR _____

PRIMARY DOCTOR _____

OTHER TREATING DRS_____
_____

IF YES, WHAT SCHOOL?_____

MARITAL STATUS S M D W

SEX M F

INSURANCE INFO

INSURANCE CO. _____
ID NO. _____
GROUP NAME AND NO. _____
_____

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER INSURANCE PLANS, PLEASE LIST
_____

Subscriber
Complete if OTHER THAN SELF

NAME_____DOB_____

☐ CHECK IF HOSPICE

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU OR ANY FAMILY MEMBERS BEEN PREVIOUSLY SEEN BY THE DOCTOR? _____

ALLERGIES?

Medication Allergies	Type of Reaction			Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No
Have you ever taken allergy shots? ☐ Yes ☐ No
If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant
Latex Allergy_____

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

PHARMACY NAME (include phone number and address if known) _____

Patient Name: _____ **DOB:** _____

***MEDICAL / SURGICAL CURRENT PROBLEMAND HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

Surgery/Management

Cardiovascular:

Coronary Artery Disease ☐ **Yes** _____
☐ **Heart attack**

Elevated cholesterol (hyperlipidemia) ☐ **Yes** _____

High Blood Pressure (hypertension) ☐ **Yes** _____
☐ **Stroke**

Gastrointestinal:

Hepatitis ☐ **Yes** _____

Gastroesophageal Reflux ☐ **Yes** _____

Genitourinary:

Renal Failure (acute) ☐ **Yes** _____

Ear / Nose / Throat: (HEENT)

Cataracts ☐ **Yes** _____

Glaucoma ☐ **Yes** _____

Chronic ear infections (otitis media) ☐ **Yes** _____

Hearing loss ☐ **Right** ☐ **Left** ☐ **Both**
☐ **Current Hearing Aid**

Sinus problems (chronic sinusitis) ☐ **Yes** _____

Nasal polyps ☐ **Yes** _____

Nasal allergies ☐ **Yes** _____

Recurrent tonsillitis ☐ **Yes** _____

Tinnitus ☐ **Yes** _____

Vertigo ☐ **Yes** _____
☐ **History of Falls**

Hematologic:

Anemia ☐ **Yes** _____

Bleeding Disorder ☐ **Yes** _____

Immunologic:

Seasonal Allergies Type: _____ ☐ **Yes** _____

Food Allergies Type: _____ ☐ **Yes** _____

HIV / AIDS ☐ **Yes** _____

Multiple Sclerosis ☐ **Yes** _____

Integumentary

Eczema/Psoriasis ☐ **Yes** _____

Infectious Disease:

Mononucleosis ☐ **Yes** _____

Metabolic/endocrine:

Diabetes Type: _____ ☐ **Yes** _____

Thyroid deficiency (hypothyroidism) ☐ **Yes** _____

Thyroid excess (hyperthyroidism) ☐ **Yes** _____

Musculoskeletal

Arthritis ☐ **Yes** _____

Neoplastic:

Cancer Type: _____ ☐ **Yes** _____

Neurologic:

Migraine ☐ **Yes** _____

Parkinson's ☐ **Yes** _____

Seizure Disorder ☐ **Yes** _____

Obstetric:

Currently Pregnant ☐ **Yes** Due Date_____

Psychiatric:

Depression (major) ☐ **Yes** _____

Drug addiction ☐ **Yes** _____

Pulmonary:

Asthma ☐ **Yes** _____

COPD/Emphysema ☐ **Yes** _____

Sleep Apnea ☐ **Yes** _____

Tuberculosis ☐ **Yes** _____

Other:_____

_____

Injury

Head ☐ **Yes** _____

Facial Fracture ☐ **Yes** _____

Injury Due to ☐MVA ☐Work Injury

Date of Accident _____

If YES to any of the above Diagnosis - was surgery performed?

What_____ **Where/When**_____ **By Who**_____

Patient Name: _____ **DOB:** _____

FAMILY HISTORY:

Allergies	☐ **Yes**	Migraines	☐ **Yes**
Asthma	☐ **Yes**	Renal disease	☐ **Yes**
Blood disease	☐ **Yes**	Seizure disorder	☐ **Yes**
Cancer Type: _____	☐ **Yes**	Other: _____	
Diabetes	☐ **Yes**		
Eczema	☐ **Yes**		
Hearing deficiency	☐ **Yes**		

SOCIAL HISTORY:

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**
_____**# Drinks** ☐**per day** ☐**per week**
Caffeine Consumption?
☐ **Yes** ☐ **No Amount per day?** _____

Please complete the Review of Systems if you have Medicare (on SEPARATE form)

What is the reason you are here today? _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for the non-covered services. I authorize the physician to release any information required. I understand and agree that (regardless of my insurance statue) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

I acknowledge that Otolaryngology Plastic Surgery Association, P.C. will exchange information regarding past medical and medication history for your care and treatment purposes.

Patient Signature: _____ **Date:** _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance with supplying accurate insurance information and understanding our payment policies.

For you information, please be aware that it may be necessary as part of your treatment to do some diagnostic tests. Many insurance companies, particularly PPO's process these in office tests under your individual surgical deductible which may incur more out of pocket costs.

Payment for office visits is due at the time of your visit. We accept checks, cash, and credit cards. We will be happy to help you process your insurance claim for reimbursement. A receipt will be issued after payment is made which will provide all the codes and fees necessary to your insurance company. We will submit for any hearing tests or other procedures that are done in our office. After your insurance company pays their allotted amount for any procedures we submit, you will be billed the remaining balance. We must emphasize that as health care providers, our relationship is with you and not the insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are ultimately your responsibility from the day the services are rendered. We realize that there are exceptions to our rules, and these are listed as follows:

MEDICARE: We are participating physicians in Medicare and therefore will submit for the patient. After we receive payment, we will bill the patient for any deductible or co-insurance balance. We will submit to your co-insurance if you provide us with the correct information and/or insurance forms to do so.

PENNSYLVANIA BLUE SHIELD: We will submit all procedure claims to PA Blue Shield. We will receive payment directly and you will receive an Explanation of Benefits from them. This will explain what has been paid and what is your responsibility.

WORKMAN'S COMPENSATION AND AUTOMOBILE: The account will be placed in the patient's name. If this information is inaccurate, the bill will remain 100% the patient's responsibility and we will expect payment at the time of service. Please bring information including name and address of the insurance company to be billed and employer information, a valid claim and policy number, and the adjuster's name.

HMOs: (AETNA/US HEALTHCARE, KEYSTONE HEALTH PLAN EAST, CIGNA, ETC.): At the present time we are participating in these insurances and will file all the necessary forms for you provided you have provided us with a valid referral or authorization form and paid your co-pay. Failure to bring the proper referral form will result in 1) rescheduling your appointment or 2) the patient paying for the visit in full. Sorry, no exceptions to this – this is the insurance company's rule, not ours.

PPO INSURANCES: At the present time, we are enrolled in several PPO programs. If you have one we **participate with,** we will file all claims for you.

DEPENDENT CHILDREN: The parent who brings the child in for his/her visit is responsible for payment.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have any questions or uncertainties, PLEASE do not hesitate to ask us.

I have read and understand the above financial policy of Otolaryngology Plastic Surgery Associates, PC and agree to abide by this policy.

Patient or Guardian Signature: _____ Date: _____

Patient Name_____