ENT of Denver, PC
Owen Reichman, MD   Anya Miller, MD   Mallory Sessions, PA-C

Patient Information

Patient's Name: (Last, First Middle)			Birth date:	Sex: ☐ M ☐ F
Street Address:	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Email Address:		Marital Status:		
Other family members seen here:				

Billing and Insurance Information

Subscriber's Name: (Last, First, Middle)			Birth date:	Sex: ☐ M ☐ F
Street Address: (if different from patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Primary Insurance:	Patient's relationship to subscriber: ☐ Self ☐ Spouse/Partner ☐ Child			
Member Identification Number	Group Number	Customer Service/Provider Service Phone Number		
Claims Mailing Address	City, State	Zip		
Secondary Insurance:	Patient's relationship to subscriber: ☐ Self ☐ Spouse/Partner ☐ Child			
Member Identification Number	Group Number	Customer Service/Provider Service Phone Number		
Claims Mailing Address	City, State	Zip		
Who should receive statements and billing/insurance notices?	Address (if different than above)			

Parent/Guardian Information (Minors Only)

Parent/Guardian Name: (Last, First Middle)			Birth date:	Sex: ☐ M ☐ F
Street Address: (if different than patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Parent/Guardian Name: (Last, First Middle)			Birth date:	Sex: ☐ M ☐ F
Street Address: : (if different than patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	

USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing the Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Michelle Wallen
Telephone: 303-316-7048
Email: michelle@entdenver.com
Address: 4500 E. 9th Ave Suite 610, Denver, CO 80220

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to either the Contact Persons listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,______________________________ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

HOME________________________ **WORK**________________________ **CELL**_________________________

Phone: for all the above numbers:

☐ Do ☐ Do Not leave message on my answering machine.
☐ Do ☐ Do Not leave message with any other person.

Mail: I want you to contact me at the following address ____

Email: I want you contact me at the following email address____

Fax: I want you to contact me by fax at ____

Other: Other requests for confidential communications (specify)____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

☐ Yes ☐ No Name:______________________ Relationship:_______________ Phone______________

HIPAA Approved Contacts

Please list any family member, personal friend or other third party you give us permission to share your protected health information

Name:	Phone Number	Relationship:

I, ______________________________ (print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activates and health care operations.

Signature:____ Date:____________________________

Revised 12/2015

FINANCIAL POLICY

Financial Policy:
In order to reduce confusion and misunderstanding between our patient and the practice, we have adopted the following financial policy. If you have any questions please feel free to discuss them with your billing staff. We are dedicated to providing the best possible care and service to you and your family we feel that your complete understanding of our financial policies is an essential element of your care and treatment.

Unless other arrangements have been made in advance, full payment for office services is due at the time of service. For your convenience, we accept: VISA, MasterCard, Discover and American Express, as well as cash, check or money order.

About Health Insurance:

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive payment from your insurer, we will refund any overpayment to you.

About Participating Health Plans:

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment or anticipated out of pocket expense **at the time of service.**

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of the statement from our office.

For all services rendered to minor patients, we will look to the adult accompanying the patient and parent or guardian with custody for payment.

It is your responsibility to verify that this office participates with your insurance. If we do not participate with your insurance, you will be responsible for all charges out of pocket.

We want to make it easy for you to pay any balance you may owe us for services. Just present your credit, debit or health savings account (HSA) card when you check into our office. You'll be able to simply and securely approve a charge to your account that will only be made if a balance remains after your insurance company has processed your claim for services provided.

- If you wish, you can limit the amount that can be charged to your credit card or HSA card. Should your insurer advise us that you have a balance due, your account will be charged only for the amount due, not to exceed the amount you have authorized.

- We will send you a letter confirming the final total charged to your card for the date of service. Should your balance due exceed the amount you authorized to be charged to your credit or HSA card, we will send you a bill for the remaining balance.

By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature:____ Date:______________________________

ENT of Denver, PC

Patient Name ______________________ **Date of Birth** ______________ **Date** ______________

Primary Care Physician ______________________ **Referring Physician** ______________________

Pharmacy (Please be sure to include the location *or* phone number) ______________________

Race ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American ☐ Pacific Islander ☐ Other ☐ Decline to state

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to State

Primary Language ☐ English ☐ Spanish ☐ Russian ☐ Other: ______________________

Person Completing This Form: Name ______________________ **Relationship to Patient** ______________________

Medications

(Please list all medications and dosages you are currently taking. Including over the counter and herbal supplements)

Medication	Dose	How Often	Reason for Taking (Condition)	Date Started	Prescribed By

Medication Allergies

Do you have any allergies to medications? If yes, please list medication and the reaction to it.

Medication	Reaction	Medication	Reaction

Non-Medications Allergies - Do you have a known allergy to any of the following?

Food Allergies: ☐Eggs ☐Peanuts ☐Seafood ☐ Other ______________________

Contact Allergies: ☐Iodine ☐Latex ☐Adhesive Tape ☐ Other ______________________

Allergy Testing: Have you had prior allergy testing? ☐ Yes ☐ No When ______________ Where______________

Results: ☐ None ☐ Animal Dander ☐ Dust ☐ Grass Pollen ☐ Mold ☐ Ragweed Pollen ☐ Tree Pollen ☐ Weed Pollen

Other ______________________

Past Medical History Have you been diagnosed with any of the following conditions?

Cancer

- ☐ Breast
- ☐ Lung
- ☐ Lymphoma
- ☐ Skin(Type): ______________
- ☐ Throat
- ☐ Thyroid
- ☐ Other Cancer (Type): ______________

Head and Face

- ☐ Migraine Headaches

Eyes

- ☐ Cataracts
- ☐ Dry Eye
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Uncorrectable Vision

Ears

- ☐ Cholesteatoma
- ☐ Frequent Ear Infections
- ☐ Hearing Loss
- ☐ Otosclerosis

Nose and Sinuses

- ☐ Chronic Sinusitis
- ☐ Deviated Septum
- ☐ Nasal Allergies
- ☐ Nasal Polyps
- ☐ Recurrent Sinusitis

ENT of Denver, PC

Patient Name______________________________ **Date of Birth**______________ **Date:** ____________

Mouth and Throat
- ☐ Chronic Tonsillitis
- ☐ Peritonsillar Abscess
- ☐ Sleep Apnea

Heart and Blood Vessels
- ☐ Atrial Fibrillation (A.Fib)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Elevated Blood Cholesterol
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Value Prolapsed

Lungs Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Sarcoidosis
- ☐ Tuberculosis (TB)

Stomach and Digestive
- ☐ GERD
- ☐ Hepatitis (☐ A ☐ B ☐ C)
- ☐ Stomach Ulcer

Genitourinary
- ☐ Currently Pregnant
- ☐ Prostate Enlargement
- ☐ Kidney Disease
- ☐ Renal Failure

Bones, Joint, Muscles
- ☐ Arthritis (Osteo)
- ☐ Arthritis (Rheumatoid)
- ☐ Fibromyalgia
- ☐ Osteoporosis

Brain and Nervous System
- ☐ Alzheimer's Disease
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Transient Ischemic Attack

Mental and Emotional Health
- ☐ Anxiety
- ☐ Depression

Endocrine, Metabolic
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Thyroid Nodule

Blood and Lymph Node
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Hemophilia
- ☐ Sickle Cell Disease

Immune and Infectious Problems
- ☐ History of Anaphylaxis
- ☐ AIDS
- ☐ Autoimmune Disorder
- ☐ HIV Positive
- ☐ Lupus
- ☐ Sjogren's Syndrome

Other ______________

Surgery

Have you ever had any reaction or problem with anesthesia? ☐ No ☐ Yes

What was the reaction? When did it occur? ____

Procedure	Date	Procedure	Date

Have you ever been hospitalized for a medical problem (non-surgical) ☐ No ☐ Yes

When/Reason for Admission ____

Family History

☐ No family history of significant health problems ☐ Patient was adopted, family history is unknown

	Grandparent(s)	Mother	Father	Brother(s)	Sister(s)
Problems With Anesthesia	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Other Cancer______________	☐	☐	☐	☐	☐
Chronic Ear Infections, Childhood	☐	☐	☐	☐	☐
Chronic Ear Infections, Adulthood	☐	☐	☐	☐	☐
Hearing Loss Before Age 20	☐	☐	☐	☐	☐
Hearing Loss After Age 20	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Bleeding/Clotting Problems	☐	☐	☐	☐	☐
Allergies Required Treatment	☐	☐	☐	☐	☐
Other ________________	☐	☐	☐	☐	☐

ENT of Denver, PC

Patient Name_______________________________ **Date of Birth**______________ **Date:** ____________

Test and Immunizations

Have you had an Influenza (Flu) Vaccine? ☐ No ☐ Yes When (Month/Year) ___________________________

Have you had a Pneumococcal Vaccine? ☐ No ☐ Yes When (Month/Year) ___________________________

Have you ever had a Colonoscopy? ☐ No ☐ Yes When (Month/Year)___________________________

Social History

Occupation ________________ ☐ Retired

Current Tobacco Use:
- ☐ None ☐ Cigarettes
- ☐ Smokeless Tobacco ☐ Cigars

Give closest amount you smoke/use per day.
- ☐ ½ pack ☐ 1 pack
- ☐ 2 packs ☐ 3 packs
- ☐ Other ___________________

History of Tobacco Use:
- ☐ None ☐ Cigarettes
- ☐ Smokeless Tobacco ☐ Cigars

When did you quit? ______________________

Alcohol Beverages

A drink is 1 shot of liquor, 1 glass of wine, 1 beer.
- ☐ None
- ☐ Less than 12 drinks per year
- ☐ 1-13 drinks per month
- ☐ 4-14 drinks per week
- ☐ >2 drinks per day

Do you use recreational Drugs?
- ☐ Yes ☐ No

Do you use marijuana?
- ☐ Medicinally ☐ Recreationally ☐ No

Caffeine Use (servings per day)
- ☐ None ☐ 1 per day
- ☐ 2-3 per day ☐ 4 or more per day

Are you exposed to secondhand smoke?
- ☐ Yes ☐ No

Home Living Situation (mark all that apply)
- ☐ Alone ☐ With spouse
- ☐ With children ☐ With mother
- ☐ With father ☐ Lives in assisted living
- ☐ Nursing home ☐ Other ______________

Assistive Medical Devices/Needs
- ☐ Legally Blind ☐ Uses Hearing Aid
- ☐ Uses Wheelchair ☐ Supplemental Oxygen
- ☐ Other ________________________________

Review of Systems Do you have or have you recently had any of the following symptoms?

Weight ___________ **Height**_____________

General Health
- ☐ Excessive Daytime Tiredness
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia
- ☐ Other Sleeping Problems
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Itchy Eyes
- ☐ Loss Of Vision
- ☐ Pain In Eye(S)
- ☐ Watery Eye(S)

Ears
- ☐ Dizziness
- ☐ Drainage
- ☐ Hearing Loss
- ☐ Infection
- ☐ Itchy Ears
- ☐ Ear Pain
- ☐ Pressure In The Ears
- ☐ Ringing In The Ears

Nose
- ☐ Facial Pressure
- ☐ Nasal Congestion
- ☐ Nasal Itching
- ☐ Mouth Breathing
- ☐ Nosebleeds
- ☐ Postnasal Drainage
- ☐ Runny Nose

Mouth and Throat
- ☐ Belching Sour Material
- ☐ Dry Mouth
- ☐ Frequent Throat Clearing
- ☐ Hoarseness Or Voice Change
- ☐ Sensation Of Something Caught In The Throat
- ☐ Snoring
- ☐ Sore Throat
- ☐ Sores In The Mouth

Cardiovascular
- ☐ Blacking Out/Fainting
- ☐ Chest Pain
- ☐ Swelling Of Ankles/Legs

Respiratory
- ☐ Productive Cough
- ☐ Non-Productive Cough
- ☐ Sleep Disturbance Due To Breathing
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn/Indigestion
- ☐ Nausea
- ☐ Coughing After Swallowing
- ☐ Swallowing – Painful
- ☐ Swallowing Difficulty
- ☐ Vomiting

Musculoskeletal
- ☐ Painful Joints
- ☐ Stiffness In Joints
- ☐ Swelling In Joints

Neurological
- ☐ Change In Smell
- ☐ Change In Taste
- ☐ Headache
- ☐ Seizures

Endocrine
- ☐ Increased Appetite
- ☐ Feels Cold

Hematology/Lymphatic
- ☐ Bleeds Excessively
- ☐ Bruise Easily
- ☐ Masses (Lumps), Armpit
- ☐ Masses (Lumps), Neck

Allergic, Infectious
- ☐ Hives
- ☐ Seasonal Rhinitis
- ☐ Sneezing

Other_____________

ENT of Denver, PC

Patient Name__________________________________ **Date of Birth**_______________ **Date:** ______________

History of Present Illness

Chief Complaint Please describe the main reason or symptom(s) for your visit today.

____

Present Illness Please describe the history of illness/symptoms that has caused you to seek care with us.

____

____

____

How long have the symptoms been present? ____

Is there a time of day or season of year when the symptoms are worse? ____________________________

Is this a recurrent problem? ☐ No ☐ Yes When was the first episode? ____________________________

Have there been any changes in duration or frequency of episodes? _________________________________

What were the circumstances when your problems first occurred (i.e. bad cold, injury, etc?) _____________

____

What makes the symptoms better? (i.e. rest, home remedies, movement, etc.)_________________________

____

What makes the symptoms worse? (i.e. environment, activity, etc.) ____________________________________

____

Have any diagnostic tests been performed (please list when and where they were completed)?______________

____

What treatments have been tried so far? Was there any improvement with them? Was there any adverse reaction to the treatment?

____

____

Additional Information/Concerns:____

____

____

____

____

____

____

____

____

____