



# SONORAN

EAR  
NOSE  
THROAT  
AUDIOLOGY

## MEDICAL HISTORY FORM

FULL NAME:

\_\_\_\_\_  
First Middle (Opt.) Last

DATE OF BIRTH:

TODAY'S DATE: \_\_\_\_\_

CHIEF COMPLAINT (REASON FOR VISIT):

HEIGHT (INCHES): \_\_\_\_\_

WEIGHT (LBS): \_\_\_\_\_

PAIN LEVEL (0-NO PAIN TO 10-WORST PAIN OF LIFE): \_\_\_\_\_

ALLERGIES:

None Known

DRUG NAME

REACTION (E.G., RASH)

SEVERITY (LEVEL 1-MILD TO LEVEL 4-SEVERE)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

MEDICATIONS

IF MORE SPACE NEEDED, CHECK HERE AND USE BACK OF SHEET

DRUG NAME:

DOSAGE

FREQUENCY

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_

PAST MEDICAL DIAGNOSES (E.G., HYPERTENSION):

- 1) \_\_\_\_\_ 6) \_\_\_\_\_
- 2) \_\_\_\_\_ 7) \_\_\_\_\_
- 3) \_\_\_\_\_ 8) \_\_\_\_\_
- 4) \_\_\_\_\_ 9) \_\_\_\_\_
- 5) \_\_\_\_\_ 10) \_\_\_\_\_

**PAST SURGICAL HISTORY**  IF MORE SPACE NEEDED, CHECK HERE AND USE BACK OF SHEET

**SURGERY TYPE (E.G., TONSILLECTOMY)**

**Date/Location**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

**ANESTHESIA HISTORY:**  No Complications  Prior Complication \_\_\_\_\_   
Family History of Complications \_\_\_\_\_

**SOCIAL HISTORY:**

**TOBACCO USE:**  Never  Former (Quit when \_\_\_\_\_)  Light User  Heavy User  
**ALCOHOL USE:**  Yes (drinks per day \_\_\_\_\_)  No  
**DRUG USE:**  Yes  No  
**CAFFEINE USE:**  Yes (drinks per day \_\_\_\_\_)  No  
**OCCUPATION:** \_\_\_\_\_

**FAMILY HISTORY:**  Unknown

**RELATIVE**

**Medical Condition(s)**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_

**REVIEW OF SYSTEMS**  None Apply

Ear	Nose	Throat	Resp
<input type="checkbox"/> Pain	<input type="checkbox"/> Drainage	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Cough
<input type="checkbox"/> Drainage	<input type="checkbox"/> Congestion	<input type="checkbox"/> Swallowing Issues	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Hearing Changes	<input type="checkbox"/> Odor	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain	<input type="checkbox"/> Snoring	<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Tinnitus/Ringing	<input type="checkbox"/> Bloody Nose	<input type="checkbox"/> Dry Mouth	
<input type="checkbox"/> Pressure	<input type="checkbox"/> Loss of smell		
Cardiovascular	Gastrointestinal	Genitourinary	Constitutional
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Fevers
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Fatigue
			<input type="checkbox"/> Night Sweats
Neurologic	Skin	Psychiatric	Musculoskeletal
<input type="checkbox"/> Headaches	<input type="checkbox"/> Skin Growths	<input type="checkbox"/> Depression	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Seizures	<input type="checkbox"/> Changing Mole	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Numbness	<input type="checkbox"/> Dry/Itchy Skin	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> TMJ Syndrome
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Rash	<input type="checkbox"/> Stress	
<input type="checkbox"/> Double Vision			

**PHARMACY**

PHARMACY NAME:

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PHARMACY ADDRESS OR

CROSS STREETS:

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PHARMACY PHONE NUMBER

(IF KNOWN):

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**PROVIDER INFORMATION**

PRIMARY CARE

PHYSICIAN/PROVIDER:

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REFERRING PHYSICIAN IF

DIFFERENT:

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HOW DID YOU HEAR ABOUT

SONORAN EAR NOSE AND

THROAT?

---

SIGNATURE:

---

Date:

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**PATIENT INFORMATION**

**FULL NAME:**

\_\_\_\_\_  
First Middle (Opt.) Last

**DATE OF BIRTH:**

\_\_\_\_\_  
TODAY'S DATE: \_\_\_\_\_

**SEX:**

Male  Female

**MOBILE PHONE:**

\_\_\_\_\_  
 I do not have a mobile phone

**MAY SEND MOBILE TEXT NOTIFICATIONS?**

Yes  No

**MAY SEND VOICE NOTIFICATIONS?**

Yes  No

**EMAIL ADDRESS:**

\_\_\_\_\_  
 Yes  No

**MAY SEND EMAIL NOTIFICATIONS?**

**HOME PHONE:**

**WORK PHONE:**

**PREFERRED METHOD OF CONTACT?**

Home Phone  Mobile  Email  
 Mail  Work Phone

**HOME ADDRESS:**

**CITY/STATE/ZIP:**

\_\_\_\_\_

**PAYMENT INFORMATION**

SELF PAY, CHECK HERE AND SKIP TO DEMOGRAPHICS

**PRIMARY INSURANCE**

**POLICY HOLDER NAME:**

**POLICY HOLDER ADDRESS:**

**POLICY HOLDER DATE OF BIRTH:**

\_\_\_\_\_

**POLICY HOLDER SS#:**

\_\_\_\_\_

**POLICY HOLDER PHONE NUMBER:**

**INSURANCE NAME:**

**POLICY ID #:**

\_\_\_\_\_

**GROUP #:**

\_\_\_\_\_

**EFFECTIVE DATE:**

\_\_\_\_\_

**RELATIONSHIP TO INSURED:**

Self  Spouse  Child  Other

**EMPLOYER NAME:**

**EMPLOYER ADDRESS:**

**CITY/STATE/ZIP:**

\_\_\_\_\_

## SECONDARY INSURANCE

POLICY HOLDER NAME:

POLICY HOLDER ADDRESS:

POLICY HOLDER DATE OF BIRTH:

Policy Holder  
SS#:

POLICY HOLDER PHONE NUMBER:

INSURANCE NAME:

POLICY ID #:

GROUP #:

EFFECTIVE DATE:

RELATIONSHIP TO INSURED:

Self

Spouse

Child

Other

### DEMOGRAPHICS

PREFERRED LANGUAGE:

English

Spanish

Other, Please Specify:

RACE:

White

African  
American

American  
Indian/Alaska Native

Pacific Islander

Asian

Other/Choose not to  
specify

ETHNICITY:

Hispanic or Latino

Non Hispanic or Latino

### EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME:

RELATIONSHIP TO PATIENT:

PHONE NUMBER:

ADDRESS:

CITY/STATE/ZIP:

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Sonoran Ear Nose and Throat. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_



# SONORAN | EAR NOSE THROAT AUDIOLOGY

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

*I hereby acknowledge that I have been presented with a copy of Sonoran Ear Nose and Throat Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.*

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

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### OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement**, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_



### **Financial Policy**

Welcome to our office! We are pleased that you have chosen Sonoran Ear Nose and Throat to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept cash, personal checks, and credit cards for payment on your account. If you have insurance, which we do not contract with, you will be expected to make a full payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay and deductible at the time of your visit.

**COMMERCIAL/PRIVATE INSURANCE:** As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

**CONTRACTED INSURANCE:** We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

**In the event Sonoran Ear Nose and Throat is not contracted with your health plan, you will be responsible for any out of network, coinsurance, or deductible applied.**

*Initial here*

**NO INSURANCE:** If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

**MEDICARE:** We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance at the time of service.

**NO SHOW FEE:** In the event your appointment is not canceled 24 hours in advance and/or you do not show for your appointment, there will be a \$25.00 fee assessed to your account.

**RETURNED CHECKS:** In the event your bank returns your check to our office unpaid, there will be a \$25.00 return check fee charged to your account.

**NON-PAYMENT:** In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Sonoran Ear Nose and Throat and have provided to the best of my ability the information requested accurately and completely.

\_\_\_\_\_  
Patients/Responsible Party Signature

\_\_\_\_\_  
Date



# SONORAN | EAR NOSE THROAT AUDIOLOGY

## Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave a detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system or with a trusted family member. It should be noted that our current notice of privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s). Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it.

### Please choose one of the following:

- I DO CONSENT** for Sonoran Ear Nose and Throat and his staff to leave detailed messages:

I, \_\_\_\_\_ give Sonoran Ear Nose and Throat permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

- Answering machine \_\_\_\_\_ Initials \_\_\_\_\_
- My cell phone \_\_\_\_\_ Initials \_\_\_\_\_
- Spouse (name) \_\_\_\_\_  
Phone number(s) \_\_\_\_\_ Initials \_\_\_\_\_
- Other (name) \_\_\_\_\_  
Phone number(s) \_\_\_\_\_ Initials \_\_\_\_\_
- Other (name) \_\_\_\_\_  
Phone number(s) \_\_\_\_\_ Initials \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

- I DO NOT CONSENT** to leave detailed messages on my phone or answering machine or with any member of my family.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

- REVOCAION OF PRIOR CONSENT:** I wish to rescind or stop the above authorizations.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient \_\_\_\_\_

Print Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_





# SONORAN | EAR NOSE THROAT AUDIOLOGY

## CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. Procedure cancellations require 5-7 business day advance notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No Show three (3) or more times and/or cancel four (4) or more times in a 12-month period, may be dismissed from the practice and thus will be denied any future appointments.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

**Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.**

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**Patient Name (Please Print)**

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**Date of birth**

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**Signature of Patient or Patient Representative**

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**Date**