Everyone's ENT & Sinus Center

Christine Gilliam, M.D.
21738 Hardy Oak Blvd. Ste. 103
San Antonio, TX 78258
Tel. (210) 647-3838
Fax (210)403-3166
www.everyonesent.com

PATIENT DEMOGRAPHICS AND HEALTH HISTORY

Patient Last Name: _____**First:** _____**MI:** _____**DOB:**_____

Address: _____ **City:** _____ **Zip Code**_____

Phone: _____ **cell/home/other** **Patient SS#:** _____

Email: _____

Guarantor (if pt a minor): _____ **Phone:** _____ **cell/home/other**

Guarantor SS/DOB#: _____/_____ **Insurance Policy Network:** _____

Insurance ID/Policy #: _____ **Insurance Group #:** _____

Reason for Visit: _____

Primary Care Doctor:_____ **Referring Doctor:**_____**Pharmacy/Intersection:**_____

PAST HEALTH

Do you now or have you had any of the following problems?

Asthma	**Yes or No**
Heart Disease	**Yes or No**
High Blood Pressure	**Yes or No**
Prior Heart Attack	**Yes or No**
Bleeding Disorder	**Yes or No**
Facial Injury	**Yes or No**
Diabetes	**Yes or No**
AIDS/HIV positive	**Yes or No**
Snoring	**Yes or No**

CANCER: Type_____**Date:** _____

Are you pregnant or trying to become pregnant?

Yes or No

OTHER IMPORTANT ISSUES: _____

_____

_____

_____

_____

_____

SURGICAL HISTORY

Have you had any problems with anesthesia? **No** **Yes**

If yes, please list what sort of problems _____

Have you ever had prolonged bleeding after surgery? **No** **Yes**

Have you ever had any of the following SURGERIES? **No** **If YES mark any of the following you have had.**

Ear Tubes _____	**Date:**_____	**Adenoidectomy**_____	**Date:**_____
Ear Surgery_____	**Date:**_____	**Tympanoplasty** _____	**Date:**_____
Mastoidectomy_____	**Date:**_____	**Heart Bypass** _____	**Date:**_____
Septoplasty _____	**Date:**_____	**Heart Stent** _____	**Date:**_____
Sinus Surgery_____	**Date:**_____	**Tracheostomy**_____	**Date:**_____
Thyroidectomy_____	**Date:**_____	**Transplant Surgery** _____	**Date:**_____
Tonsillectomy_____	**Date:**_____	**Splenectomy**_____	**Date:**_____
Other Surgery_____	**Date:**_____	**Other Surgery**_____	**Date:** _____

Is there a family history of the following:

Bleeding disorders ___**No** ___**Yes** **If yes, which family member** _____

Allergies ___**No**_____**Yes** **If yes, which family member** _____

Anesthesia Problems ___**No**_____**Yes** **If yes, which family member** _____

(cont on next page)

Do you currently smoke? No Yes # of years_____ Ave. Packs/Day _____
Are you a former smoker? No Yes Second hand smoke history: ___None ___Currently exposed
Alcohol usage? ___None_____Occasionally____Daily Use recreational drugs? _____Yes_____No

Are you taking ANY medication right now? (This includes prescription and over-the-counter medications)

☐ **No** ☐ **Yes If yes, please list below.**

Medication	Medication	Medication

Are you *ALLERGIC* to ANY *MEDICATION*? ☐ **No** ☐ **Yes If yes, please list below.**

Name of Medication	Type of Reaction

Are you allergic to Latex?____No ___Yes Are you allergic to Lidocaine? ___No_____Yes

REVIEW OF SYSTEMS

<u>CIRCLE</u> any problems you have or had recently in the following areas:

General: Appetite Loss, Chills, Fatigue, Fever, Night Sweats, Weight Gain, Weight Loss
Skin: Change in Wart/Mole, Dryness, Hair Loss, Hives, Itching, Rash, Skin Color Changes
HEENT: Blurred Vision, Excessive Tearing, Eye Pain, Eye Redness, Hearing Loss, Decreased Hearing, Ear Discharge, Ear Pain, Ringing in the Ears, Nose Bleed, Nasal Congestion, Hoarseness and Voice Changes
Neck: Neck Mass, Neck Pain, Neck Stiffness, Swollen Glands
Respiratory: Cough, Difficulty Breathing, Snoring, Wheezing
Cardiovascular: Chest pain, Difficulty Breathing Or Exertion, Fainting/Blacking Out, Palpitations, Shortness of Breath
Gastrointestinal: Abdominal pain, Hematemesis, Heartburn, Nausea, Vomiting
Musculoskeletal: Muscle pain, Muscle Weakness
Neurological: Fainting, Headaches, Incoordination/Falls, Seizures, Spinning Sensation, Unusual Sensation, Weakness,
Psychiatric: Anxiety, Change in Sleep Pattern
Endocrine: Excessive Thirst
Hematology: Abnormal Bleeding, Easy Bruising, Enlarged Lymph Nodes, Pinpoint Hemorrhages

Patient or Guardian Signature:_____Date: _____

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OFFICE POLICY ON PAYMENT:

It is our policy to require payment on all patient responsibilities for any office charges at the time of service.

CANCELLATION POLICY:

Office visits cancelled or rescheduled within 48 hours and/or two business days prior to scheduled appointment will result in $25.00 cancellation fee.

Audiology visits cancelled or rescheduled within 48 hours and/or two business days prior to scheduled appointment will result in $50.00 cancellation fee.

Surgery and procedures cancelled or rescheduled within FIVE business days prior to scheduled appointment will result in $50.00 cancellation fee.

INSURANCE POLICY:

It is the goal of the Physicians at Everyone's ENT & Sinus Center to offer you the best treatment plan based on the most accurate diagnosis. To obtain the diagnosis, our providers may recommend procedures or tests to be performed during your visit including but not limited to scopes into your nose and/or throat, hearing tests, allergy testing, CT scan.

Additional diagnostic procedures and tests are not included in a routine office visit and will result in additional charges. You are financially responsible for charges that may be billed to you as a result of any diagnostic procedures/tests performed. Depending on your specific benefit plan the procedure/test charges may be applied to an annual deductible or coinsurance.

Insurance provides reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. In addition, accounts you are considered a guarantor for will also be paid with any credit on the account prior to a refund being issued.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the release of any medical information necessary to process claims and I permit a copy of this authorization to be used in place of an original. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I hereby authorize Everyone's ENT & Sinus Center to apply for benefits on my behalf for covered services and request that payment from my insurance company be made directly to Christine Gilliam M.D., P.A.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to Christine Gilliam M.D., P.A. to apply to my account, should a balance exist.

For your convenience, we accept payment methods: cash, debit card, major credit cards and Care Credit.

I have read the above and accept financial responsibility in full for this account.

SIGNED:_____**DATE:** _____

Patient, Parent, or Guardian (please circle)

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME:_____

ADDRESS:_____

PHONE NUMBER: _____

RELATIONSHIP: _____

Christine Gilliam, MD | Everyone's ENT & Sinus Center
21738 Hardy Oak Suite 103, San Antonio, TX 78258 ~ Tel.: (210) 647-3838 ~ Fax: (210) 403-3166

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Our office is dedicated to maintain the privacy of your Protected Health Information. This includes such data as your name, address, phone number, date of birth, Social Security number, account information, medical record number, or any other unique identifying number. In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my Protected Health Information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:_____ Date of Birth: __/__/_____ Last 4 digits of SSN: _____

I authorize Everyone's ENT & Sinus Center to *RELEASE* copies of my records TO:

_____
Name of Physician or Institution, etc.

_____
Address (Please FULLY complete!)

_____
City, State, ZIP

_____
Phone Number FAX Number

_____
Dates of treatment for which you need records

I authorize Everyone's ENT & Sinus Center to *OBTAIN* copies of my records FROM:

_____
Name of Physician or Institution, etc.

_____
Address (Please FULLY complete!)

_____
City, State, ZIP

_____
Phone Number FAX Number

_____
Dates of treatment for which you need records

*****PLEASE CHECK ALL THAT APPLY:**

Information to be RELEASED:

___ Office Notes ___Pathology
___ Audiograms ___CT Sinus Scans
___Labs ____U/S Thyroid
___Allergy Testing
___Other:_____

PLEASE SEND REQUESTED RECORDS TO:

ATTENTION MEDICAL RECORDS
Everyone's ENT & Sinus Center
21738 Hardy Oak Blvd. Suite 103
San Antonio, TX 78258

Tel.: (210)647-3838 Fax: (210-403-3166

Information will be used / disclosed for the following purpose(s):

_____ Continuation of Care (for another Provider) _____Pending Appointment Date:_____

_____ Personal Use _____Other:_____

The patient or the patient's representative MUST read and initial the following statements:

____1. I understand that my health care will not be affected if I do not sign this form.

____2. I understand that I may revoke this authorization at any time, in writing, by notifying our office at: Everyone's ENT & Sinus Center, 21738 Hardy Oak Blvd. Ste. 103, San Antonio, TX 78258. Phone: (210) 647-3838. If I do revoke the Authorization, it will not have any effect on any actions taken by Everyone's ENT & Sinus Center prior to their receipt of the Revocation.

____3. Unless otherwise noted, I understand this authorization WILL EXPIRE when ALL REQUESATED RECORDS have been transferred OR when a period of NINETY DAYS has transpired.

____4. I understand that routine requests may take up to 15 business days to process.

____5. I understand that my records may be faxed or mailed via United States Post Office.

_____ _____
Signature of patient or patient's representative **Date**

_____ _____
Printed name of patient or patient's representative **Relationship to Patient**

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I,_____, have been offered a copy of

(Patient Name Printed)

Everyone's ENT & Sinus Center's Notice of Privacy Practices.

*_____ _____

Signature of Patient/Parent or Guardian Date

A copy of the HIPPA regulations can be found in the black folder at the front desk window. A copy can also be found on our website for your review. Please review it at your leisure. Please ask the front desk receptionist for a copy if you desire one to take home.