

MRN _____

CANONICO EAR, NOSE AND THROAT, P.C.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone (____) _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ - _____ - _____ Marital Status: S M D W

Emergency Contact Name: _____ Emergency Phone: (____) _____

Relationship to Patient: _____

Name of Provider that referred you: _____ Is this your PCP? Yes No

PLEASE CHECK ONE:

Is this visit related to a Motor Vehicle Accident Yes No

Is this visit related to a Workers Comp Accident Yes No

Please see our Financial Policy as we do not bill Automobile Insurance or Workers Comp.

RESPONSIBLE PARTY: **(If self, check the box and skip this section)** POA

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

Male Female Home #: (____) _____ Cell #: (____) _____ Work#: (____) _____

Street Address: _____

City: _____ State: _____ Zip: _____

INSURANCE HOLDER INFO: **(If self, check the box and skip this section)**

Primary Insurance Co. _____

Policy ID No. _____ Group No. _____

Policy Holder Name _____ DOB _____ Male Female

Policy Holder SSN: _____ - _____ - _____ Phone (____) _____

Street Address _____ City _____ State _____ Zip _____

Subscriber's Employer _____

MRN _____

CANONICO EAR, NOSE AND THROAT, P.C.

Secondary Insurance Co. _____

Policy ID No. _____ Group No. _____

Policy Holder Name _____ DOB _____ Male Female

Policy Holder SSN: _____ - _____ - _____ Phone (____) _____

Street Address _____ City _____ State _____ Zip _____

Subscriber's Employer _____

Pharmacy Name: _____ Phone: (____) _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

I give consent to Canonico Ear, Nose, and Throat, P.C. to view my prescription history.

Signature: _____ **Date:** _____

PAYMENT OF ALL DEDUCTIBLES/COPAYS, COINSURANCES AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

ACKNOWLEDGEMENT AND CONSENT

Initial _____ I will notify Canonico Ear, Nose and Throat, P.C. of any changes in the above information.

Initial _____ My signature below authorizes payment of medical benefits to the provider for services performed, certified information provided is accurate and complete and acknowledges that this office will file my insurance as a courtesy.

Initial _____ My deductible/ copayments/ coinsurance must be paid on the day of my appointment.

Initial _____ I acknowledge that if I have an office procedure, this may appear on my insurance explanation of benefits as a surgical code and I may incur a charge in addition to my copay. This will be determined by my insurance company at the time my claim is processed by my insurance company.

Initial _____ I authorize my insurance benefits to be paid directly to Canonico, Ear, Nose and Throat, P.C. and authorize release of all medical information needed to determine benefits payable on my behalf. I understand that I am financially responsible for any balance which will be billed to me once the insurance company has paid their portion. If my insurance company states that I have a pre-existing period, there is a possibility that they

may not pay for these procedures and I understand that I will be responsible for the entire amount. I

am aware that if the provider I see does not participate with my insurance plan, I will possibly have a higher deductible, copay or coinsurance for my visit due to the provider being a non-participating provider for my insurance plan, and I agree to pay for this amount on the date of service. I realize all charges incurred by myself or my dependents are my financial responsibility, as well as all collection and attorney fee that result from nonpayment.

Initial _____

I authorize release of my medical records to my referring physician. I authorize the release of my medical records, knowledge of me or my health, and that of my family to this provider. A photographic copy of this authorization shall be valid as the original.

Initial _____

I acknowledge that a copy of the Patient Financial Policy and Patient Privacy Notice is available to review and I am aware I may obtain a copy of either of these upon request.

I CONSENT TO MEDICAL EVALUATION AND TREATMENT PERFORMED BY THE PROVIDER

Patient/Guardian Signature

Date

Canonico Ear, Nose, and Throat, P.C. follows **HIPAA** guidelines to ensure the integrity of your privacy. We need your help in ensuring your privacy by providing us with the following information. Canonico Ear, Nose, and Throat, P.C. has my permission to call me and leave a message and/or text message on the telephone number(s) provided. In the event that I, _____, cannot be reach personally, Canonico Ear, Nose, and Throat, P.C. may leave any test result, lab result, appointment information, or other confidential medical or financial information to the following designated individuals:

Name	Relationship to Patient	Contact Phone Number

Release of your protected health information (PHI) to anyone other than the patient or parent/legal guardian will be restricted to those individuals listed above or individuals otherwise listed on the Notice of Privacy Practices.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CANONICO EAR, NOSE AND THROAT, P.C.

PATIENT MEDICAL HISTORY

Thank you for choosing Canonico Ear, Nose and Throat, P.C.. Please take a few moments to provide us with the following medical information. This will assist us in providing you with the best possible medical care and will expedite your visit. Your assistance is greatly appreciated.

Name: _____
DOB: _____ **Age:** _____
Referring Physician: _____
Expectation of today's visit: _____

Have you had any special tests done? If yes, what and when? _____

REVIEW OF SYSTEMS

Have you ever had problems or disease in the areas listed?

Please Check One:	No	Yes	Explain
Eyes	___	___	_____
Ears	___	___	_____
Nose	___	___	_____
Mouth	___	___	_____
Throat	___	___	_____
Lungs/COPD/Asthma	___	___	_____
Heart	___	___	_____
Stomach/Colon	___	___	_____
Neurological/Brain	___	___	_____
Kidneys/Bladder	___	___	_____
Blood Disorder	___	___	_____
Liver/Hepatitis	___	___	_____
Extremities/Bones	___	___	_____
Circulation	___	___	_____
Psychiatric/Mental	___	___	_____
Immune System/AIDS	___	___	_____
Endocrine System	___	___	_____
Diabetes	___	___	_____
Skin	___	___	_____
High Fever	___	___	_____
Weight Loss/Gain	___	___	_____
High Blood Pressure	___	___	_____
Others Not Listed	___	___	_____

SURGICAL HISTORY

- No Surgeries

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

	No	Yes	Which Family Member?
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Lung Disease	___	___	_____
Kidney Disease	___	___	_____
Diabetes	___	___	_____
Liver Disease	___	___	_____
Cancer	___	___	_____
Hearing Loss	___	___	_____
Other	___	___	_____

SOCIAL HISTORY

	No	Yes	Amount
Do you smoke or chew tobacco?	___	___	_____
Do you drink alcohol?	___	___	_____

Have you ever been exposed to loud noise? **No** **Yes**
 What type of loud sounds? (Check all that apply.)

- ___ gunfire ___ lawn mowers
- ___ firecrackers ___ heavy equipment
- ___ explosions ___ motorcycles/recreational vehicles
- ___ power tools ___ music
- ___ factory work ___ farm machinery

If yes, do you use hearing protection **No** **Yes**
 Were you in the military? **No** **Yes**

Do you have pets in the house?

- Cat(s) **No**___ **Yes**___ Dog(s) **No**___ **Yes**___
- Bird(s) **No**___ **Yes**___ Other(s) **No**___ **Yes**___

MEDICATIONS/VITAMINS/SUPPLEMENTS

- No Daily Medication(s)

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES

- No Drug Allergies

Drug Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient or Legal Guardian

Date