ADULT PATIENT INFORMATION

How did you hear about our practice? _____

Patient Name: _____ Sex: [] M [] F
First M.I. Last

Date of Birth: ____/____/_____ Age: _____ Social Security #: _____

Marital Status: [] Married [] Single [] Divorced [] Widowed Race: _____ Ethnicity: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____

Preferred Communication Method (circle all that apply) Call Text Email

Employer: _____ Work Phone: (____) _____

EMERGENCY CONTACTS:

Name _____ Phone (____) _____ Relationship_____

Name _____ Phone (____) _____ Relationship_____

Preferred Pharmacy: _____
Name Location

Referring Physician: _____ **Primary Care Physician:** _____

Primary Insurance: _____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Self ☐ Other: _____
Name / DOB/ Employer

Secondary Insurance: _____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Self ☐ Other: _____
Name / DOB/ Employer

Tertiary Insurance: _____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Self ☐ Other: _____
Name / DOB/ Employer

_____ _____ _____
Signature of Patient / Legal Guardian **Relationship** **Date**

2020

***** PLEASE TURN OVER, READ & SIGN *****

2020

SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS

FINANCIAL POLICY

Thank you for choosing Spokane Valley Ear, Nose & Throat and Facial Plastics for your healthcare needs. The following information is being provided to assist you in understanding our financial policies. If you have any questions, always feel free to contact our billing office at (509) 928-6044 and we will be happy to help you.

ACCOUNT RESPONSIBILITY You are responsible for all charges incurred on your account. It is your responsibility to make sure that the information we have is current and accurate and to know what your insurance contract benefits will cover and pay.

INSURANCE BILLING If you have medical insurance, we will be happy to bill your insurance carrier(s) for you. **OFFICE VISITS AND PROCEDURES PERFORMED IN THE OFFICE ARE CONSIDERED SEPARATE BY MOST INSURANCE COMPANIES AND MAY GO TOWARD YOUR DEDUCTIBLE.** You will also need to check amounts of copays, deductibles and if referrals are required. If your insurance requires a referral, it is **your** responsibility to make sure that referral is in place prior to your appointment. **Insurance cards, DSHS Provider One cards and copays are always due at the time of service. If these are not presented, we may have to reschedule your appointment.** Any unpaid balance after insurance pays is the patient's responsibility.

SURGERY POLICY If you are having surgery and/or a procedure in the office or at a facility, as a courtesy we will check with your insurance for authorization needed and for **estimated** co-insurance/deductible amounts. Our billing department will notify you before surgery if we need to collect a co-ins/deductible amount prior to your surgery. If you are not able to pay the co-insurance/deductible estimate before surgery, we will be happy to reschedule your surgery to a more convenient time.

PAYMENT TERMS **Balances** ***are due in full within 30 days of receiving statement,*** unless arrangements have been made. All delinquent accounts will be turned over to our Collection Agency after 90 days. An interest charge of 1% will be added monthly to unpaid balances at 60 days.

NO INSURANCE If you have no insurance, payment in full is expected at time of service, unless arrangements have been made prior to your visit.

PAYMENT METHODS We accept cash, personal checks, Visa, Mastercard, American Express, and Discover.

NSF CHECKS A $35.00 service charge will be assessed on all NSF checks.

LAB CHARGES All blood work, cultures and biopsies will be charged by an independent lab.

INSURANCE & FMLA PAPERWORK Forms submitted to us for completion such as insurance forms or FMLA are subject to a $30.00 fee to cover administrative costs.

I have read and understand each of the above items.

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____ revised 01/30/15

SPOKANE VALLEY EAR, NOSE & THROAT (SVENT)
Notice of Privacy Practices

By signing this form, you acknowledge that you have been informed that Spokane Valley Ear, Nose & Throat and Facial Plastics (SVENT) provides information about how we may use and disclose your protected health information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Spokane Valley Ear, Nose & Throat and Facial Plastics may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

Please check all that apply:

Can we leave a message on your answering machine/voicemail? ☐ **Yes** ☐ **No**

Can we leave a message for you at your work number? ☐ **Yes** ☐ **No**

Can we discuss your medical condition with family or friends who call the office?

☐ **Yes** ☐ **No** If yes, whom may we speak to? _____

_____

_____

This section to be completed by Minors aged 13-18

For Minors Ages 13-18

I DO ☐ I DO NOT ☐ authorize my parent / guardian to view or access **ALL** my medical records, including any sensitive information. (Including reproductive care, sexually transmitted diseases, HIV/AIDS, drug and/or alcohol abuse and mental health)
This authorization will remain in effect until the age of 18 or until revoked by you.

Minor Signature if applicable _____ Date _____

Questions and/or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer, Karen Caudill at 509-340-8316.

Patient's Printed Name: _____ Patient's Date of Birth: _____

Signature _____ Date _____
(Patient/Parent/Guardian) (Mo/Day/Yr)

Adult Hearing Health Assessment

PATIENT'S NAME_____ / /

First MI Last Age Date

How did you hear about our office:

◯ Website ◯ TV ◯ Yellow Pages ◯ Employer ◯ Newspaper ◯ Radio ◯ Insurance

◯ Referred by a Physician: _____

◯ Referred by a friend: _____

◯ Other: _____

Primary Concerns: _____

Hearing :

◯ Hearing loss: Right Left

◯ Sudden Change in hearing: Right Left

◯ Tinnitus /Ringing/Buzzing: Right Left

◯ Dizziness: _____

◯ Ear Pain Right Left

◯ Ear Fullness Right Left

◯ Ear surgery: _____

◯ Head Trauma: _____

◯ Family History of hearing Loss: _____

◯ History of noise exposure (describe) : _____

_____

Does a hearing problem:

	Always	Sometimes	Never
• Make it difficult for you to converse on the telephone?			
• Cause others to complain that the TV or radio are too loud?			
• Cause you difficulty following conversation in a restaurant?			
• Limit or hamper your personal or social life?			
• Cause you to have to ask people to repeat themselves?			
• Cause difficulty understanding speech in background noise?			
• Cause difficulty hearing women's or children's voices?			
• Cause you to feel as though others mumble?			
• Create stress or feel tired when listening for long periods of time?			

Hearing aids:

Do you currently wear hearing aids ◯ Yes ◯ No How long _____

Are you satisfied with them? _____

Office use only :

Today's Date: _____

Spokane Valley Ear, Nose & Throat and Facial Plastic Surgery **New Patient History Form**

Name: _____ DOB: _____ Age: _____

Referring Physician: _____

Reason for Your Visit: _____

How Long Have You Had Symptoms? _____

Past Medical History

Circle which of the following you have or had:	**Please Specify:**
Diabetes/ thyroid /endocrine problems	_____
Heart / vascular problems	_____
Lung problems/ asthma /pneumonia	_____
Kidney or urinary problems	_____
Liver problems or viral hepatitis	_____
Bleeding or clotting problems	_____
Cancer or any tumors	_____
Neurologic/ brain problems /headaches	_____
Depression/ anxiety /psychiatric	_____
HIV or AIDS	_____
Osteoarthritis or joint problems	_____
Rheumatoid arthritis/ lupus /autoimmune	_____
Hearing or vertigo disorders	_____
Gastroesophageal reflux / esophageal	_____
Speech or swallowing disorders	_____
Sinus/ nasal /eye /facial problems	_____
Skin disorders	_____
Sleep Disorders/Apnea/CPAP	_____

Past Surgical History List all surgeries you have had:

_____

_____

_____

_____

Family History

Indicate which of the following run in your <u>family</u>: Father Mother Sibling Other

Cancer or Benign tumors	☐	☐	☐	☐	_____
Hearing loss	☐	☐	☐	☐	_____
Allergies or Asthma	☐	☐	☐	☐	_____
Bleeding or clotting disorders	☐	☐	☐	☐	_____
Heart or lung problems	☐	☐	☐	☐	_____
Diabetes, thyroid, endocrine problems	☐	☐	☐	☐	_____
Lupus, Multiple Sclerosis, autoimmune	☐	☐	☐	☐	_____
Neurologic or genetic conditions	☐	☐	☐	☐	_____

Social History

Occupation / what you do for work: _____

Who do you live with? _____

Tobacco /smoking: ☐ never ☐ previous, when did you quit? _____ ☐ Yes, how Often? _____

Environmental in-home smoke exposure: ☐ Yes ☐ No

Alcohol consumption: ☐ daily ☐ 1-4 times /week ☐ less than 1 time /week ☐ never

Recreational drugs: ☐ heroin or opioids ☐ cocaine ☐ marijuana ☐ other _____

<u>Medications:</u> (Include dosage, frequency and list all herbal, over-the-counter, & topical treatments)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

<u>Drug Allergies:</u> List drug and reaction: ☐ None known

_____

_____

_____

SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS SYSTEM REVIEW

Please circle if *you* have *ever* had any of the following:

Constitutional Symptoms

Recent Headaches.....	No	Yes
Recent weight change.....	No	Yes
Recent Fever.....	No	Yes
Recent Fatigue.....	No	Yes

Eyes

Eye disease or injury.....	No	Yes
Wear glasses/contacts.....	No	Yes
Blurred/double vision.....	No	Yes
Glaucoma.....	No	Yes

Ears/Nose/Mouth/Throat

Hearing Loss/ringing.....	No	Yes
Earaches or drainage.....	No	Yes
Chronic sinus problems.....	No	Yes
Nose bleeds.....	No	Yes
Mouth sores.....	No	Yes
Bleeding gums.....	No	Yes
Bad breath or taste.....	No	Yes
Sore throat/voice change.....	No	Yes
Swollen glands in neck.....	No	Yes

Cardiovascular

Heart trouble/Disease.....	No	Yes
Chest pain.....	No	Yes
Palpitations.....	No	Yes
Shortness of breath.....	No	Yes
Swelling of feet/ankles.....	No	Yes
High blood pressure.....	No	Yes

Respiratory

Chronic/frequent cough.....	No	Yes
Spitting up blood	No	Yes
Asthma.....	No	Yes
Wheezing.....	No	Yes
Sleep Apnea.....	No	Yes

Gastrointestinal

Loss of appetite.....	No	Yes
Nausea/vomiting.....	No	Yes
Rectal bleeding.....	No	Yes
Abdominal pain.....	No	Yes
Ulcer.....	No	Yes

Psychiatric

Nervousness.....	No	Yes
Depression.....	No	Yes
Insomnia.....	No	Yes

Genitourinary

Frequent Urination.....	No	Yes
Incontinence.....	No	Yes
Blood In urine.....	No	Yes

Musculoskeletal

Joint pain.....	No	Yes
Weakness of muscles.....	No	Yes
Muscle pain/cramps.....	No	Yes
Difficulty Walking.....	No	Yes
Arthritis.....	No	Yes

Neurological

Frequent Headaches.....	No	Yes
Recurring headaches.....	No	Yes
Seizures/Convulsions.....	No	Yes
Numbness/Tingling.....	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes
Head Injury.....	No	Yes
Memory loss.....	No	Yes

Endocrine

Glandular/hormone.....	No	Yes
Thyroid disease.....	No	Yes
Diabetes.....	No	Yes
Excessive thirst.....	No	Yes
Heat/cold intolerance.....	No	Yes

Hematologic/Lymphatic

Slow to heal.....	No	Yes
Easy bruising/bleeding.....	No	Yes
Anemia.....	No	Yes
Hepatitis.....	No	Yes
HIV.....	No	Yes

Allergic/immunologic –

Have you ever had a bad reaction to any of the following:

Antibiotics.....	No	Yes
Penicillin.....	No	Yes
Morphine/Demerol/Codeine.....	No	Yes
Aspirin.....	No	Yes
Tetanus or other serum.....	No	Yes
Iodine.....	No	Yes
Shell fish.....	No	Yes
Narcotics.....	No	Yes
Anesthesia.....	No	Yes
Acute Infections.....	No	Yes
Latex.....	No	Yes

Other _____

Cancer/Other _____

Signature _____

Patient/Guardian

Last updated 01/05/11