

Ronald A. Van Tuyl, M.D., FACS

Personal History Form

NAME: _____ AGE: _____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____

OCCUPATION: _____ EDUCATION: _____ MARITAL STATUS: _____

REASON FOR VISIT: _____

DO YOU SMOKE OR HAVE YOU SMOKED IN THE PAST? _____ HOW MUCH: _____

DO YOU DRINK ALCOHOL? _____ HOW OFTEN: _____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? IF YES, PLEASE LIST: _____

Medical History

EAR, NOSE, THROAT AND RESPIRATORY SYMPTOMS

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING CONDITIONS

DIFFICULTY HEARING	YES	NO	DIZZINESS	YES	NO
SINUS TROUBLE	YES	NO	NASAL BLOCKAGE	YES	NO
POST NASAL DRAINAGE	YES	NO	NOSE BLEEDS	YES	NO
EAR INFECTION/DRAINAGE	YES	NO	PERSISTENT HOARSENESS	YES	NO
DIFFICULTY BREATHING	YES	NO	ASTHMA	YES	NO
CONSTANT COUGH	YES	NO	PNEUMONIA/BRONCHITIS	YES	NO
COUGH UP BLOOD	YES	NO	COUGH UP PHLEGM/SPUTUM	YES	NO

OTHER PAST HISTORY

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING CONDITIONS

CHEST PAIN	YES	NO	HYPERTENSION	YES	NO
MIGRAINES	YES	NO	HEART MURMUR	YES	NO
WEIGHT LOSS/GAIN	YES	NO	DIABETES	YES	NO
HEARTBURN	YES	NO	OTHER _____		

PLEASE LIST ANY PRESCRIPTION DRUGS YOU ARE TAKING:

- | | |
|----|----|
| 1 | 5 |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

PLEASE LIST ANY NON PRESCRIPTION DRUGS YOU ARE TAKING:

- | | |
|----|----|
| 1 | 5 |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

PLEASE LIST ANY HOSPITALIZATION OR SURGERIES YOU HAVE HAD:

- | DATES | REASON FOR PROCEDURE |
|--------------|-----------------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

PATIENT'S SIGNATURE

DATE

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT,
AND TREATMENT CONSENT**

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to **Ear Nose Throat and Allergy** for services furnished to me by **Ear Nose Throat and Allergy**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **Ear Nose Throat and Allergy** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Ear Nose Throat and Allergy**. **Secondary Insurance:** I request that payment of authorized secondary insurance benefits be made on my behalf to **Ear Nose Throat and Allergy** if possible or otherwise to me, at which time I would forward all payment to **Ear Nose Throat and Allergy**.
2. **Release of Information:** **Ear Nose Throat and Allergy** may disclose all or any part of medical record and/or financial ledger to any person or corporation(1) which is or may be liable or under contract with **Ear Nose Throat and Allergy** for reimbursement for services rendered and (2) any health care provider for continued patient care. **Ear Nose Throat and Allergy** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.
3. **Non-Covered Services:** I understand that **Ear Nose Throat and Allergy** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.
4. **Financial Agreement:** As a courtesy we will file your insurance, but if after 6 weeks your insurance has not responded to the claim filed, you will be notified that the unpaid balance is now your responsibility and payable within 2 weeks of notification. I agree that in return for the services provided to me by **Ear Nose Throat and Allergy** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Ear Nose Throat and Allergy** for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Furthermore, by signing below I acknowledge that I have been made aware that there is a \$25.00 fee for all returned checks and a \$35.00 fee for any missed appointments where proper notice is not given. **The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.**
5. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **Ear Nose Throat and Allergy Notice of Privacy Practices**.
6. **Notice:** Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.
7. **Treatment Consent:** By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.
8. **Additional Disclosure Authority:** Please indicate any additional parties we are allowed to speak with regarding your account (please circle):
 - **Spouse?** Name _____ **YES NO Immediate Family? YES NO**
 - **Other?** Name _____ **YES NO**
 - **Can we leave a message regarding your health information on your answering machine?** **YES NO**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient, Guardian or Representative

Date

Please Print name

Relationship to Patient

Patient's Date of Birth