

MEDICAL HISTORY

Date _____

(Confidential)

Name _____ Age _____ SS# _____
Last First Middle

Chief Complaint _____
(What is the main problem that brings you here?)

Current Medications _____

Drug Allergies _____

Have you taken any aspirin, Ibuprofen or arthritis medicine in the last two weeks? **Y** **N**

If so, when? _____ Do you bleed or bruise easily? _____

Referring Doctor _____ Primary Care Physician _____

Phone (_____) _____ Phone (_____) _____

Address _____ Address _____

REVIEW OF SYSTEMS

(Please check all that apply)

GENERAL

___ Weight Loss
___ Fever or Chills
___ Bad Reaction to Anesthesia
Self _____ Family _____
Describe _____
___ Easy Bleeding or Bruising
Self _____ Family _____
Describe _____
___ Recent Trauma or Injury
Describe _____

HEAD, EYE, EAR, NOSE AND THROAT

___ Headache
___ Seizures
___ Stroke
___ Double Vision
___ Hearing Loss
___ Ear Pain
___ Dizziness
___ Nasal Obstruction
___ Hayfever
___ Hoarseness
___ Thyroid Problems
___ Other _____

CHEST

___ Asthma
___ Shortness of Breath
___ Cough
___ Coughing up Blood
___ Emphysema
___ Lung Disease
___ Other _____

CARDIOVASCULAR

___ Chest Pain
___ Heart Disease
___ High Blood Pressure
___ Heart Murmur
___ Shortness of Breath at Night
___ Other _____

GASTROINTESTINAL

___ Difficulty Swallowing
___ Nausea or Vomiting
___ Stomach Pain
___ Ulcers
___ Liver Disease
___ Blood in Stool
___ Other _____

GENITOURINARY

___ Painful Urination
___ Difficult Urination
___ Blood in Urine
___ Other _____

OTHER

___ Diabetes
___ Arthritis
___ Cancer _____
___ Other ^{type} _____

PAST HISTORY

Please be sure to write down all surgical procedures, particularly sinus surgeries

Surgical Procedure _____ Date _____ Dr. _____
_____ Date _____ Dr. _____
_____ Date _____ Dr. _____
_____ Date _____ Dr. _____

Medical Illness _____ Date _____ Dr. _____
_____ Date _____ Dr. _____
_____ Date _____ Dr. _____

Hospitalizations _____ Date _____ Dr. _____
_____ Date _____ Dr. _____
_____ Date _____ Dr. _____
_____ Date _____ Dr. _____

FAMILY HISTORY

Mother is ___ Alive ___ Deceased Father is ___ Alive ___ Deceased
Medical Problems _____ Medical Problems _____
Blood Relatives Medical Problems _____

SOCIAL HISTORY

Do you exercise? Y N How often? _____ Type of Exercise _____
Do you smoke? Y N Cigarettes per Day _____ Cigars? ___ Pipe? ___ Chewing Tobacco? ___
How long have you been chewing or smoking? _____

Do you drink alcohol? Y N Social Heavy Prior Addiction Date Sober _____
Do you take or have you ever taken recreational drugs? Y N Prior Addiction Date Sober _____
If yes, what type of drug? _____ How Long/ How Often? _____

Have you ever have allergy testing? Y N By what doctor? _____ Did you take allergy shots? Y N
What were you allergic to? _____

GEORGIA NASAL AND SINUS INSTITUTE, P.C.

Patient Information

Date _____ Allergies _____ Male _____ Female _____

FULL LEGAL NAME _____ SS# _____

Address _____
Street City State Zip

Date of Birth ____ -- ____ -- Home Phone (____) _____ Student FT ____ PT ____

Employer _____ Work Phone (____) _____ Employed FT ____ PT ____

Marital Status S M D W Cell Phone (____) _____

Name of Spouse _____ Work/Cell Phone (____) _____

Emergency Contact _____ Phone(____) _____ Relationship _____

Pharmacy that you use regularly: Name _____ Phone (____) _____

Responsible Party (Please complete if different from above or if the patient is a minor)

Name _____ SS# _____ Date of Birth ____ -- ____ --

Address _____
Street City State Zip

Phone _____ Relationship to Patient _____

Insurance Information

Primary Insurance

_____ ID# _____ Group# _____

Insured _____ Date of Birth ____ -- ____ -- SS# _____

Relationship to Patient _____ Employer _____

Secondary Insurance

_____ ID# _____ Group# _____

Insured _____ Date of Birth ____ -- ____ -- SS# _____

Relationship to Patient _____ Employer _____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or to facilitate treatment.

Signature _____ Date _____

I assign all medical and/or surgical benefits, to which I am entitled, to Georgia Nasal and Sinus Institute. This assignment will remain in effect until revoked in writing by myself or an authorized person. A photocopy of this authorization will be considered as effective and valid as the original.

Signature _____ Date _____

I understand that if I or an authorized person does not cancel a scheduled appointment within 24 hours prior to that appointment, or present documentation of an emergency situation in a timely manner, I will be charged with a negligent cancellation fee.

Signature _____ Date _____

**GEORGIA
NASAL & SINUS
INSTITUTE**

FINANCIAL AGREEMENT

I hereby agree to pay for all office visits at the time service is rendered, unless I make arrangements in advance. I understand payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that having insurance does not relieve me of the responsibility to pay.

DATE _____ SIGNATURE _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize GEORGIA NASAL & SINUS INSTITUTE, to furnish my insurance company(s), hospital, referring physicians and attorneys all information with regard to my medical care.

DATE _____ SIGNATURE _____

AUTHORIZATION FOR MEDICARE /MEDICAID BENEFITS (if applicable)

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents, any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown.

In Medicare/Medicaid assigned cases the physician agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge. I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon charge determination of the Medicare/Medicaid carrier.

DATE _____ SIGNATURE _____

TRICARE (if applicable)

I request the payment of authorizes benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CHAMPUS and it's agents any information needed to determine these benefits or the benefits payable for related services.

DATE _____ SIGNATURE _____

GEORGIA
NASAL & SINUS
INSTITUTE

INSURANCE VERIFICATION FORM

Please Read and Answer All Questions

As the patient, it is your responsibility to provide our office with your insurance information to prevent you from incurring unnecessary medical expenses. In most cases, failure to follow procedure on your insurance plan and use of non-preferred facilities and doctors will reduce your benefits significantly. **Your signature below indicates that you have verified your insurance benefits by calling the customer service number on your insurance card, and have answered ALL questions below.** Failure to obtain this information before appointment time will cause delays as you will be required to verify benefits in the office before you will be seen by the doctor.

PATIENT NAME _____ **INSURANCE COMPANY** _____

ID # _____ **GROUP/POLICY#** _____

1. Is Dr. Kuhn/Dr. Melroy a preferred provider for your insurance company? () yes () no
If no, do you have out of network benefits? () yes () no
Deductible amount: _____ Co-Insurance amount _____.
2. Dr. Kuhn/Dr. Melroy are specialists. Does your insurance company require a *referral number* from your primary care physician (PCP) to be seen by a specialist? If so, please provide your referral number _____, and name of referring physician _____.
3. It is very common for Dr. Kuhn and Dr. Melroy to order CT Scans for our Nasal/Sinus patients, even though you may have recently had a CT Scan. Does your insurance company require *precertification*, or approval in advance, for a CT Scan of the Sinus/ Nasal Endoscopy/ Debridement? () yes () no
4. Do you have a yearly deductible to pay? () yes () no. If yes, amount of deductible \$ _____.
5. Do you have a co-pay for office an visit? () yes () no If yes, amount of co-pay per office visit? \$ _____
6. Does your insurance have a preferred laboratory for testing in the Savannah area? () yes () no
Please circle name of laboratory **Memorial Medical Center** **Candler** **Other** _____
7. Does your insurance have a preferred center for radiology in the Savannah area? () yes () no
Please circle name of Radiology Center. **Memorial Medical Center** **Southcoast**
8. Does your insurance policy have a preferred hospital in the Savannah area? () yes () no
Please circle the name of preferred hospital. **Memorial Medical Center** **Candler/St. Joseph**

I have been informed of my insurance plan's coverage and procedures, and will be responsible for all non-covered and denied charges in addition to my deductible, coinsurance, and or copayment amounts at time of visit.

Signature of Patient or Guarantor

Date