Middle Tennessee Ear, Nose & Throat-- New Patient Demographics

Please indicate any changes **Account Number:**

First, Middle Initial, Last Name:	DOB:	DOS:	Provider:
Mailing Address:		Home Phone:	Cell Phone:
Marital Status:	PCP:	REF:	Employer:
SSN:	Email:		Gender: Male Female
Primary Insurance: Subscriber # Group #	Secondary Insurance: Subscriber # Group #	Emergency Contact: Relation:	Emergency Phone:

X_____ I have verified that all of the information on this form is correct & that I will be asked to verify this every time.

As part of our effort to comply with patient centered health, we are required to gather additional demographic information for you, the patient. We appreciated your efforts to help our facility comply with Meaningful Use government regulations.

Race: □ Asian □ Native Hawaiian □ African American □ White □ Hispanic □ Pacific Islander □ Other

Ethnicity: □ Hispanic □ Latino □ Not Hispanic □ Other

Preferred Language: □ English □ Spanish □ Indian □ Russian □ Other

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Advanced Directive: Please CIRCLE the one that applies- (If you have a copy, please provide)

No Advance Directive Advanced Directive Power of Attorney Do Not Resuscitate Do Not Resuscitate & Power of Attorney

Living Will Living Will & Do Not Resuscitate Living Will & Do Not Resuscitate & Power of Attorney

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Please Initial Below:

_____ I have been given a copy of MTENT Financial Policy and I have read and understand the Policy as outlined in this brochure

_____ MTENT HIPAA policy is posted. □ I have declined a hard copy. □ I have requested & received a hard copy.

_____ As a courtesy, we will file most insurance plans. You are ultimately responsible for your balance and any non-covered charges. any delinquent balances that are referred to our collection agency will be subject to a collection fee.

_____ I hereby give Middle TN Ear, Nose & Throat consent for my medical treatment and my signature below authorizes MTENT to submit claims to the insurance(s) I have provided and I also confirm that all personal/medical/insurance information provided to Middle TN Ear, Nose & Throat is accurate and complete as the date signed below.

_____ I affirm I DO NOT have insurance coverage other than the INSURANCE(S) listed in my New Patient Demographic Form.

Patient or Guardian Signature: _____ Date: _____/_____/20_____

First and Last Name:	DOB:	DOS:	Provider:

Please list any medications and/or supplements: _____

_____

_____

Drug Allergies (please list medication and list reaction): _____

_____

_____

Medical History: (please circle yes or no for any medical problems you have had)

Heart Attack	Y N	Cancer	Y N	Anemia	Y N
Heart Disease	Y N	Sleep Apnea	Y N	Bleeding Problems	Y N
Irregular Rhythm (A-fib)	Y N	Diabetes	Y N	Blood Clot	Y N
Hypercholesterolemia	Y N	Tuberculosis	Y N	Transfusions	Y N
Hypertension	Y N	Thyroid Disease	Y N	Arthritis	Y N
Stroke	Y N	Kidney Disease	Y N	Acid Reflux/GERD	Y N
Emphysema/COPD	Y N	HIV (AIDS)	Y N	Pollen Allergies	Y N
Asthma	Y N	Hepatitis	Y N	Animal Allergies	Y N

Other Medical Problems/Hospitalizations: _____

Surgical History: (please circle yes or no for any medical problems you have had)

Tonsillectomy	Y N	Other Ear Surgery	Y N	Abdominal	Y N
Sinus Surgery	Y N	Gall Bladder	Y N	Cancer	Y N
Ear Tubes	Y N	Carotid Surgery	Y N	Heart/Lung	Y N
Nasal Surgery	Y N	Orthopedic	Y N	Hernia Repair	Y N
Thyroid/Parathyroid	Y N	Brain	Y N	Gynecologic	Y N

Other Medical Surgeries: _____

Family History: (please circle yes or no and state their relation to you)

Hearing Loss	Y N	_____	Diabetes	Y N	_____	Allergies	Y N	_____
Thyroid Disease	Y N	_____	Meniere's	Y N	_____	Stroke	Y N	_____
Heart Disease	Y N	_____	Hypertension	Y N	_____	Sleep Apnea	Y N	_____
Bleeding disorder	Y N	_____	Cancer	Y N	_____	Other	Y N	_____

Are any of these symptoms present today? Please circle Yes or No

Ear, Nose & Throat		**General**		**Respiratory**	
Difficulty swallowing	Y N	Fatigue	Y N	Cough	Y N
Ear Drainage	Y N	Fever	Y N	Hoarseness	Y N
Ear Pain	Y N	Night sweats	Y N	Shortness of breath	Y N
Hearing Loss	Y N	Weight gain	Y N	Snoring	Y N
Nasal congestion	Y N	Weight loss	Y N		
Ringing in ears/Noise	Y N				
Neurology		**Endocrine**		**Gastrointestinal**	
Headache	Y N	Heat/Cold intolerance	Y N	Nausea	Y N
Numbness/Tingling	Y N	Hot Flashes	Y N	Vomiting	Y N
Vertigo/Dizziness	Y N	Thyroid Enlargement	Y N	Heartburn	Y N
Eyes		**Cardiovascular**		**Hematology**	
Double Vision	Y N	Chest Pain	Y N	Easy bleeding	Y N
Blurred Vision	Y N	Irregular Heart Beats	Y N	Easy bruising	Y N
Changes in Vision	Y N	Rapid Heart Rate	Y N		
Genitourinary		**Psychological**			
Pain on urination	Y N	Anxiety	Y N	**Pain Management**	Y N
Frequent urination	Y N	Depression	Y N	Provider Name: _____	
Kidney Stones	Y N	Difficulty sleeping	Y N		
Integument (skin)		**Musculoskeletal**		Office Phone Number: _____	
Rash	Y N	Joint Pain/Swelling	Y N		
Skin Dryness	Y N	Muscle Pain	Y N		

Patient or Guardian Signature: _____**Date:** _____/_____/**20**_____

Middle Tennessee Ear, Nose & Throat

Account Number:

First and Last Name:	DOB:	DOS:	Provider:

Reason for today's visit: _____

Pharmacy name & location: _____

Social History:

Current Smoker Y N _____ packs/cig per day Former Smoker Y N _____ # of years quit

Never Smoker Y N Recreational drug use Y N Chewing Tobacco Y N

Alcohol use Y N if yes how much _____ how often _____

In an effort to keep our patients better informed

There are times when an office procedure is needed to correctly diagnose problems of the Ear, Nose and Throat.

Your **COPAY** covers your office visit or consultation but **May Not** cover the **"Additional Services" listed below**

Additional Services include, but are not limited to:

1. **Procedures such as:**
   a. Scopes for sinus or throat complaints
   b. Sinus Debridement after sinus surgery, septoplasty or turbinate reduction
   c. Ear wax removal or debridement of ear canal
   d. Incision & drainage
   e. Lesion removal
   f. Ear tubes
   g. Foreign body removal
2. **Audio testing**
3. **Injections**
4. **CT Scans**

The above Additional Services may be covered under your deductible/co-insurance. Insurance companies consider Procedures **A-G** as surgery, and a portion of any patient responsibility will be collected at Check-Out. Our **Billing Department** is available to assist with questions-**615-848-9265 ext 142.**

I acknowledge and have read the above information.

_____ _____

Patient/Guardian if Patient is a minor Date

Consent for Purposes of Treatment, Payment & Healthcare Operation

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to

MIDDLE TENNESSEE EAR, NOSE & THROAT. (MTENT)

Patient Name:_____ Acct #:_____

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. This protected health information also includes sending prescriptions electronically (e-scribing) and reviewing my prescription history as needed to properly prescribe appropriate medications.

I may request a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. The Notice of Privacy Practices for Practitioner is also posted in the waiting room at 1370 Gateway Blvd, Ste 100, Murfreesboro, TN & 300 StoneCrest Blvd, Ste 375, Smyrna, TN 37167. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

*Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

☐ I authorize the following individual(s) to speak with MTENT regarding my information:

Name: Relation:	Name: Relation:
Phone:	Phone:
Appointments Billing Treatment/Condition	Appointments Billing Treatment/Condition

☐ **I do not authorize anyone to receive or discuss any information about me regarding MTENT.**

☐ In providing Email - you agree to participate with our secure on-line patient portal

May we leave information on your voicemail regarding your account and/or condition? YES NO

_____ _____ _____

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

RELEASE / RESPONSIBLE PARTY for MINOR PATIENTS ONLY – FILL IN ALL BLANKS

I consent to the treatment as necessary or desirable to the care of the minor patient first names above including, but not restricted to, whatever medication, x-ray, or other studies that may be used by Middle TN Ear, Nose & Throat, nurse, or qualified designate.

I agree to be financially responsible for any charges not covered by insurance on this minor child's account.

X_____ Date_____

Signature of Parent or Guardian

Name_____Relationship to Patient_____

****(IF NOT CUSTODIAL PARENT(S), LEGAL DOCUMENTATION OF CUSTODY MUST BE PRESENTED TO RECEPTIONIST!)****

Address (*If different from above*)_____

Phone (_____)_____DOB_____/_____/_____SS#_____