

Lake Ear, Nose, Throat & Facial Plastic Surgery Associates  
601 E Dixie Ave. Plaza 901 Leesburg, FL 34748  
1501 US 441 N Suite 1402 The Villages, FL 32159  
1819 Salk Ave Tavares, FL 32778

### Patient Demographics

Date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: M or F

Employment/Student status: \_\_\_\_\_ Employer: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Which physician requested for us to see you? \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Employer Phone No: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

If patient is a **MINOR**:

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Mother's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Father's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

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I acknowledge and agree that Lake Ear, Nose, Throat & Facial Plastic Surgery Associates may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

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Print name, relationship, and phone number

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Print name, relationship, and phone number

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Print name, relationship, and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Authorized Representative

**HIPPA PRIVACY NOTICE**

I have received and/or have seen and acknowledge the HIPPA PRIVACY NOTICE of Milstead, Vaught & Madonna, MD, PA. This Privacy Notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, Katherine Thompson, PA, LuAnne Faubion, ARNP and Jenniffer Stringham, PA.

Name of patient (print): \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient of authorized representative: \_\_\_\_\_

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## **AUTHORIZATION CONSENT**

I, the below named patient, parent, guardian or authorized representative of patient, hereby consent to such medical care encompassing the routine diagnostic procedures and medical treatment by my attending physician.

## **LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT'S AND AUTHORIZATION TO RELEASE INFORMATION**

I. RELEASE OF INFORMATION - I the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient or Legal Guardian:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAST MEDICAL HISTORY---Which of the following conditions have you had?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ARTHRITIS           | <input type="checkbox"/> ASTHMA           | <input type="checkbox"/> ATRIAL FIBRILLATION |
| <input type="checkbox"/> CANCER              | <input type="checkbox"/> DIABETES         | <input type="checkbox"/> EMPHYSEMA           |
| <input type="checkbox"/> GERD                | <input type="checkbox"/> GLAUCOMA         | <input type="checkbox"/> GOITER              |
| <input type="checkbox"/> HEART ATTACK        | <input type="checkbox"/> HEART DISEASE    | <input type="checkbox"/> HEPATITIS           |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> HIV                 |
| <input type="checkbox"/> HYPERTHYROIDISM     | <input type="checkbox"/> HYPOTHYROIDISM   | <input type="checkbox"/> KIDNEY DISEASE      |
| <input type="checkbox"/> PNEUMONIA           | <input type="checkbox"/> SLEEP APNEA      | <input type="checkbox"/> STROKE              |
| <input type="checkbox"/> TUBERCULOSIS        |   |  |

**PREVIOUS OPERATIONS: \_\_\_\_\_ YES? \_\_\_\_\_ NO? If yes, please check or list, giving dates:**

- |  |  |
|--|--|
| <input type="checkbox"/> CANCER SURGERY OF HEAD/NECK     | <input type="checkbox"/> NASAL/NOSE SURGERY  |
| <input type="checkbox"/> SINUS SURGERY                   | <input type="checkbox"/> EAR SURGERY         |
| <input type="checkbox"/> FACIAL PLASTIC/COSMETIC SURGERY | <input type="checkbox"/> SKIN CANCER SURGERY |
| <input type="checkbox"/> THYROID/PARATHYROID SURGERY     | <input type="checkbox"/> HEART SURGERY       |
| <input type="checkbox"/> OTHER SURGERIES _____           |  |

**FAMILY HISTORY**

	<b>AGES OR</b>	<b>PRESENT HEALTH</b>
<b>Living? YES/NO</b>	<b>AGES @ DEATH</b>	<b>OR CAUSE OF DEATH</b>
FATHER <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
MOTHER <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
SIBLINGS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
CHILDREN <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____

**Please mark illnesses which have occurred in any of your blood relatives:**

- |  |  |   |                                 |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |                                 |

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SOCIAL HISTORY**

DO YOU USE TOBACCO NOW?  YES  NO TYPE & DAILY AMOUNT \_\_\_\_\_

HOW LONG? \_\_\_\_\_

IN THE PAST?  YES  NO TYPE & DAILY AMOUNT \_\_\_\_\_

HOW LONG? \_\_\_\_\_ IF STOPPED, WHEN?

DO YOU USE ALCOHOLIC BEVERAGES?  YES  NO IN THE PAST?  YES  NO

TYPE \_\_\_\_\_ WEEKLY AMOUNT \_\_\_\_\_ HOW LONG? \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Which of the following symptoms do you presently have?

FEVER

WATERY EYES

WEIGHT GAIN

ITCHY EYES

WEIGHT LOSS

HEARTBURN

FATIGUE

ACID REFLUX

LUMPS IN NECK

STOMACH PAIN

HEARING LOSS

PALPITATIONS

DIZZINESS

SHORTNESS OF BREATH

EAR PAIN

WHEEZING

DIFFICULTY SWALLOWING

COUGH

HOARSENESS

BLOOD TRANSFUSION

NASAL CONGESTION

BRUISING

RUNNY NOSE

SENSITIVITY TO HEAT OR COLD

SORE THROAT

SKIN LESION

SNEEZING

SKIN RASH

FACIAL PRESSURE

WEAKNESS ARMS OR LEGS

HEADACHE

NUMBNESS ARMS OR LEGS

DATE OF LAST MENSTRUAL PERIOD (IF APPLICABLE) \_\_\_\_\_

