LakeENT & FPS
Ear | Nose | Throat
& facial plastic surgery

Judith C. Milstead, MD • S. Dwight Vaught, MD • Dino Madonna, MD • J. Samuel Moak, III, MD
Leesburg: (352) 728-2404 | The Villages® • (352) 753-8448 | Tavares • (352) 343-7279 | LakeENT.net

CONTACT INFORMATION

Date: _____

Name (Last, First, Middle): _____ **Date of Birth:** _____ **Age:** ____

Address (Local Mailing Address): _____

Address (Permanent, If Not Resident): _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Employer: _____ **Email:** _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Home Phone ☐ Cell Phone

Social Security # (SSN): _____ **Marital Status:** _____ **Sex:** ☐ M ☐ F

Race: _____ **Preferred Language:** _____ **Ethnicity:** ☐ Hispanic ☐ Not Hispanic

Height: _____ **Weight:** _____

LOCAL PHARMACY

Local Pharmacy: _____ **Pharmacy Phone #:** _____

City / State: _____

EMERGENCY CONTACT

Name: _____ **Phone #:** _____ **Relationship:** _____

PRIMARY CARE

Primary Care Physician: _____

Which physician requested for us to see you? _____

RESPONSIBLE PERSON INFORMATION

☐ Spouse ☐ Mother ☐ Father ☐ Guardian

Name: _____ **SSN #:** _____ **DOB:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Employer: _____

PATIENT INSURANCE INFORMATION

Primary Insurance Name: _____ **Member ID #:** _____

Secondary Insurance Name: _____ **Member ID #:** _____

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RELEASE OF INFORMATION

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:

Print Name, Relationship and Phone Number

Print Name, Relationship and Phone Number

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.

Signature of Patient or Authorized Representative

Date

HIPPAA PRIVACY NOTICE

I have received and / or have seen and acknowledge the HIPAA PRIVACY NOTICE of Lake ENT & FPS. This notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, J. Samuel Moak, MD, Jenniffer Ferguson, PA-C, Christine Halvorsen, PA-C, Jennifer Pollard, APRN, and Blake Gelb, APRN.

Patient's Name (Print)

Date

Signature of Patient or 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 provider. I understand that my attending provider may use PRISMA to access and share medical information with my other healthcare providers. I also understand that my attending provider may utilize Sunoh.ai, an artificial intelligence (AI) tool to assist during patient encounters by generating clinical notes based on our recorded conversations. The recorded conversation will be deleted automatically within 7 days. Both PRISMA and Sunoh.ai adhere strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines and are completely voluntary.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS 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 carriers 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 PHYSICIAN'S 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 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 (Print) _____ Date _____

Signature of Patient or Authorized Representative _____

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PAST MEDICAL HISTORY

Name: _____ **Date:** _____

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Neurological
- ☐ Neuromuscular
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Cancer (Type): _____

ALLERGIES TO MEDICATIONS: _____

_____

ALLERGIES TO LATEX: ☐ Yes ☐ No

If yes, please describe reaction: _____

PREVIOUS OPERATIONS: ☐ Yes ☐ No

If yes, please check or list under OTHER SURGERIES, giving dates:

- ☐ Cancer Surgery Of Head / Neck
- ☐ Ear Surgery *Type:* _____
- ☐ Facial Plastic / Cosmetic Surgery
- ☐ Heart Surgery *Type:* _____
- ☐ Nasal / Nose Surgery
- ☐ Sinus Surgery
- ☐ Skin Cancer Surgery
- ☐ Thyroid / Parathyroid Surgery
- ☐ Other Surgeries:

_____

_____

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FAMILY HISTORY

Name: _____ Date: _____

Relationship	Living?	Age or Age at Death	Present Health or Cause of Death
Father	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Spouse	☐ Yes ☐ No		
Siblings	☐ Yes ☐ No		
Children	☐ Yes ☐ No		

PLEASE MARK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES:

☐ Abnormal Bleeding ☐ Diabetes ☐ High Blood Pressure ☐ Stroke

☐ Cancer ☐ Heart Disease ☐ Kidney Disease

SOCIAL HISTORY

Name: _____ Date: _____

Substance	Current User?	Past User?	Details
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No	Type / Daily Amount: _____ How Long? _____ If Stopped, When? _____
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	Type: _____ Weekly Amount: _____ How Long? _____

REVIEW OF SYSTEMS

WHICH OF THE FOLLOWING SYMPTOMS DO YOU PRESENTLY HAVE?

- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Lumps In Neck
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Sneezing
- ☐ Facial Pressure
- ☐ Headache
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Stomach Pain
- ☐ Palpitations
- ☐ Shortness Of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Blood Transfusion
- ☐ Bruising
- ☐ Sensitivity To Heat Or Cold
- ☐ Skin Lesion
- ☐ Skin Rash
- ☐ Weakness Arms Or Legs
- ☐ Numbness Arms Or Legs
- ☐ Snoring
- ☐ Daytime Sleepiness
- ☐ Wake Up Choking Or Gasping

MEDICATIONS

Today's Date: _____

Patient Name: _____ Date of Birth: _____

LOCAL PHARMACY

Local Pharmacy: _____

Pharmacy Phone #: _____

LIST MEDICATIONS WITH DOSAGE YOU ARE PRESENTLY TAKING

Including aspirin, oral contraceptives & vitamin supplements

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ADVANCE CARE PLAN

Do you have an Advance Directive? ☐ Yes ☐ No

*An **Advance Directive** is a legal document that explains how you want medical decisions to be made if you cannot make them yourself.*

Do you have a Living Will? ☐ Yes ☐ No

*A **Living Will** is a type of advance directive that outlines your health care wishes for end-of-life care if you become terminally ill and cannot make these decisions on your own.*

Do you have a Durable Power of Attorney for Healthcare? ☐ Yes ☐ No

*A **Durable Power of Attorney for Healthcare** is a type of advance directive that allows you to name the person you want to make treatment decisions for you if you can't speak or decide for yourself.*

Patient's Name (Print) _____ Date _____

Signature _____

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NO-SHOW POLICY

Dear Patient,

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment, so we have the option of offering that appointment to another patient who needs to see the provider.

Please let this form serve to notify you that if you fail to give us a **24-hour notice** of cancellation, there will be a **$50 no-show charge** that will be billed to your account. This charge cannot be filed to your insurance.

Thank you for understanding,
Lake ENT & FPS

Patient's Name (Print) _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____

HOW DID YOU HEAR ABOUT US?

Name: _____ **Date:** _____

Your input helps us to ensure we spend our marketing and advertising dollars wisely. Please take a moment to let us know how you learned of Lake ENT & FPS / Face 2 Face.

Please mark a CHECK in the box that best describes how you learned of our services.

- ☐ Magazine
- ☐ TV Ad
- ☐ Family Member Or Friend
- ☐ Referral From Another Doctor
- ☐ Emergency Room
- ☐ Insurance Plan
- ☐ Telephone Book
- ☐ Road or Building Sign
- ☐ Internet
- ☐ Other: _____

STAY IN THE KNOW

Stay connected with Lake ENT & FPS / Face 2 Face to receive wellness tips, specials and event updates.

Email*: _____

Additional Comments or Concerns: _____

_____

_____

**By providing your email address, you agree to receive updates, newsletters, and occasional marketing or event invitations from Lake ENT & FPS / Face 2 Face. We value your privacy and will never share your information. You can unsubscribe at any time by clicking the link at the bottom of our emails.*

Thank You For Your Time!