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

New Patient Forms

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 SYMPTOMS:

Which of the following symptoms do you presently have?

____ FEVER	____ SORE THROAT	____ COUGH
____ WEIGHT GAIN	____ SNEEZING	____ BLOOD TRANSFUSION
____ WEIGHT LOSS	____ FACIAL PRESSURE	____ BRUISING
____ FATIGUE	____ HEADACHE	____ SENSITIVITY TO HEAT OR COLD
____ LUMPS IN NECK	____ WATERY EYES	____ SKIN LESION
____ HEARING LOSS	____ ITCHY EYES	____ SKIN RASH
____ DIZZINESS	____ HEARTBURN	____ WEAKNESS ARMS OR LEGS
____ EAR PAIN	____ ACID REFLUX	____ NUMBNESS ARMS OR LEGS
____ DIFFICULTY SWALLOWING	____ STOMACH PAIN	____ SNORING
____ HOARSENESS	____ PALPITATIONS	____ DAYTIME SLEEPINESS
____ NASAL CONGESTION	____ SHORTNESS OF BREATH	____ WAKE UP CHOKING OR GASPING
____ RUNNY NOSE	____ WHEEZING	

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New Patient Forms

DATE: _____

Name _____ Date of Birth _____ Age _____

Address (local mailing address) _____

Permanent Address (if not resident) _____

Home # _____ Work # _____ Cell # _____

Employer _____ Email _____

Social Security Number _____ Marital Status _____ Sex: ☐ Male ☐ Female

Race _____ Preferred Language _____ Ethnicity _____

Height _____ Weight _____

Local Pharmacy _____ Pharmacy Phone # _____

City/State _____

Emergency Contact _____ Phone _____

Primary Care Physician

Which physician requested for us to see you? _____

Do you have an Advanced Directive? ☐ Yes ☐ No

Responsible Person Information: ☐ Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Name _____ Social Security # _____ DOB _____

Employer _____

Address _____

Phone: Work # _____ Other # _____

PATIENT INSURANCE INFORMATION

Insurance Name _____ ID # _____

Insured Party DOB _____

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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 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 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 (Print) _____ Date _____

Signature of Patient or Legal Guardian _____

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

____ ARTHRITIS	____ ASTHMA	____ ATRIAL FIBRILLATION
____ GERD	____ DIABETES	____ EMPHYSEMA
____ HEART ATTACK	____ GLAUCOMA	____ GOITER
____ HIGH BLOOD PRESSURE	____ HEART DISEASE	____ HEPATITIS
____ HYPERTHYROIDISM	____ HIGH CHOLESTEROL	____ HIV
____ PNEUMONIA	____ HYPOTHYROIDISM	____ KIDNEY DISEASE
____ TUBERCULOSIS	____ SLEEP APNEA	____ STROKE
____ NEUROMUSCULAR	____ COPD	____ NEUROLOGICAL
____ CANCER (type) _____		

ALLERGIES TO MEDICATIONS: _____

_____

_____

PREVIOUS OPERATIONS ☐ YES ☐ NO If yes, please check or list, giving dates:

____ CANCER SURGERY OF HEAD/NECK	____ NASAL/NOSE SURGERY
____ SINUS SURGERY	____ SKIN CANCER SURGERY
____ FACIAL PLASTIC/COSMETIC SURGERY	____ EAR SURGERY (type) _____
____ THYROID/PARATHYROID SURGERY	____ HEART SURGERY (Type) _____

____ OTHER SURGERIES _____

_____

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Patient Name: _____ Date: _____

FAMILY HISTORY

			AGES OR AGES AT DEATH	PRESENT HEALTH OR CAUSE OF DEATH
LIVING?	____ YES	____ NO	_____	_____
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 ____ HEART DISEASE

____ STROKE ____CANCER ____HIGH BLOOD PRESSURE ____KIDNEY DISEASE

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New Patient Forms

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

HIPPA PRIVACY NOTICE

I have received and/or have seen and acknowledge the HIPAA PRIVACY NOTICE of Milstead, Vaught & Madonna, MD, PA. This privacy notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, J. Samuel Moak, III, MD, Michael Freedman, DO, Jenniffer Ferguson, PA-C, Christine Halvorsen, PA-C, Jennifer Pollard, APRN and Lacey Morgan, APRN.

Patient's Name (Print) _____ Date _____

Signature of Patient or Authorized Representative _____

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MEDICATIONS

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Pharmacy: _____ Pharmacy Phone # _____

LIST MEDICATIONS WITH DOSAGE YOU ARE PRESENTLY TAKING

Including aspirin, oral contraceptives & vitamin supplements

Judith C. Milstead, MD • S. Dwight Vaught, MD • Dino Madonna, MD • J. Samuel Moak, III, MD

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