New Patient Information Form

7165 Getwell Road
Building H, Suite 1
Southaven, MS 38672
Phone: (662)349-7676 **Fax:** (662)349-7679

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Social Security # _____ Age: _____ Marital Status: _____ Race:_____ Ethnicity:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referred By: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Reason for Visit Today:_____

If you are here today for a broken nose or object in ears or nose, please specify the date it occurred: _____

GUARDIAN/SPOUSE INFORMATION

Guardian or Spouse Name: _____ Cell Phone:_____

DOB: _____ Social Security # _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

***Must have Social Security Number for the Policy Holder.**

Insurance Company Name: _____

Claims Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____ ID #: _____ Group #: _____

Insured Name: _____DOB: _____ Social Security #: _____

SECONDARY INSURANCE

***Must have Social Security Number for the Policy Holder.**

Insurance Company Name: _____

Claims Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____ ID #: _____ Group #: _____

Insured Name: _____DOB: _____ Social Security #: _____

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of the receiving services from Northwest MS Otolaryngology
7165 Getwell Road, Building H, Suite 1
Southaven, MS 38672

1. All services are provided to you with the understanding that you are responsible for the cost, regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. We bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive.

2. **Deductible/co-insurance and/or co-pay will be due at the time of service.** We accept cash, check, and credit card of Master Card, Visa, and Discover Card. Any past due balance on account will be due or payment arrangements made prior to your next appointment.

3. You are responsible for knowing if a **referral authorization** is required by your insurance company. Make sure you know what physicians are in your plan, what facilities are covered, and what ancillary services you must use. If we can be of assistance, please let us know. **KNOW YOUR BENEFITS. It is your responsibility to notify this office of insurance coverage changes.**

4. Any unpaid charges over 90 days old (without a prior payment arrangement) will be turned over to our outside collection agency with additional collection fees. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process.

5. **No show appointment patients will be charged a fee of $50.00**, as this is an appointment spot that we could be seeing another patient. If you do not plan to keep your appointment, please call and cancel between the hours of 8:00 a.m. and 5:00 p.m. This charge is *not billable* to your insurance company; this is your full responsibility and will have to be paid prior to scheduling next appointment.

6. **Returned checks are subject to a $30.00 return check fee.**

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize Desoto Thyroid and Endocrinology to share my medical information and medical records to my insurance company and third party payers. I assign any benefits I may have for reimbursement of my medical treatment received by Northwest MS Otolaryngology of which I may be entitled to from any insurance coverage, worker's compensation benefits, or any other payer with whom services are files.

_____ _____

Patient/Guardian Signature Date

Patient's Name: _____ DOB: _____ Date: _____

Medical History

__ADHD
__Alcohol/Substance Abuse
__Allergies
__Alzheimer's
__Anxiety
__Arthritis
__Asthma
__Bleeding/Blood Problem
__Cancer What kind?_____
__Congenital Abnormalities
__COPD
__Coronary Artery Disease (CAD)
__Dementia
__Depression
__Diabetes
__Exposed to Fumes, Dust, Solvents
__Gastroesophageal Reflux (GERD)
__Glaucoma
__Headaches
__Hearing Loss
__Heart Problems
__High Blood Pressure
__High Cholesterol
__Hyperthyroidism
__Hypothyroidism
__Kidney Problems
__Liver Problems
__Mental Illness
__Osteopenia
__Osteoporosis
__Otitis Media, Chronic
__Seizures
__Stroke
__Thyroid Cancer
__Thyroid Problems

Prior Surgeries	**What year?**
__Appendectomy	_____
__Cholecystectomy (Gallbladder)	_____
__Coronary Artery Bypass Grafting	_____
__Hysterectomy	_____
__Mastectomy	_____
__Parathyroidectomy	_____
__Sinus Surgery	_____
__Thyroidectomy	_____
__Tonsillectomy	_____
__Ear Tubes	_____
__Adenoidectomy	_____
__Other: _____	_____

Prior screenings/vaccines

Date of last breast cancer screening _____
Date of last colorectal cancer screening_____
Date of last influenza vaccine _____
Date of last pneumonia vaccine_____
Do you have an advanced care plan? **Yes** **No**
If yes, who is your surrogate?
_____

Social History

Do you currently use tobacco?	__Yes__No	How much?_____
In the past, did you use tobacco?	__Yes__No	Quit date?_____
Are you around smoke?	__Yes__No	
Do you drink Alcohol?	__Yes__No	How many drinks daily?____
Do you currently use illegal drugs?	__Yes__No	If so, what kind?_____
In the past, did you use illegal drugs?	__Yes__No	If so, what kind?_____

Family History

__ADHD
__Alcohol/Substance Abuse
__Allergies
__Alzheimer's
__Anxiety
__Arthritis
__Asthma
__Bleeding/Blood Problems
__Cancer What kind?_____
__Congenital Abnormalities
__COPD
__Coronary Artery Disease (CAD)
__Dementia
__Depression
__Diabetes
__Exposed to Fumes, Dust, Solvents
__Gastroesophageal Reflux (GERD)
__Glaucoma
__Headaches, Migraines
__Hearing Loss
__Heart Problems
__High Blood Pressure
__High Cholesterol
__Other:_____
__Hyperthyroidism
__Hypothyroidism
__Kidney Problems
__Liver Problems
__Mental Illness
__Osteoporosis/Osteopenia
__Otitis Media, Chronic
__Seizures
__Stroke
__Thyroid Cancer
__Thyroid Problems

Patient's Name: _____ **DOB:** _____ **Date:** _____

Current Medications

(Please bring all medications with you to your appointment.)

Name of Medication	Dosage	How many per day?

Allergies to Medications

Name of Medication	Type of Reaction

Do you currently have trouble with any of the following on a regular basis?

General	No	Yes
Recent weight change	___	___
Fever/chills/night sweats	___	___
Fatigue	___	___
Sleep problems	___	___
Loss of appetite	___	___

Eyes	No	Yes
Vision difficulty	___	___
Concerns about eyes	___	___

Ears/Nose/Throat	No	Yes
Hearing difficulty	___	___
Sinus problems	___	___
Nose or throat concerns	___	___

Cardiovascular	No	Yes
Chest pain	___	___
Palpitations/irregular heart beat	___	___
Shortness of breath while lying flat	___	___
Swelling of legs	___	___
History of heart murmur	___	___
Rheumatic heart disease	___	___

Respiratory	No	Yes
Frequent cough	___	___
Coughing up blood	___	___
Shortness of breath	___	___
Wheezing	___	___
History of TB	___	___
History of asthma	___	___
History of pneumonia	___	___

Gastrointestinal	No	Yes
Abdominal pain	___	___
Heartburn	___	___
Change in bowel patterns	___	___
Blood in stool	___	___
Black tarry stool	___	___
Nausea	___	___
Vomiting	___	___
Frequent diarrhea	___	___
Constipation	___	___
Trouble swallowing	___	___
History of ulcers, gallstones	___	___

Genitourinary	No	Yes
Frequent urination	___	___
Burning or painful urination	___	___
Incontinence or dribbling	___	___
Trouble initiating stream	___	___
Weak urine stream	___	___
Sexual difficulty or concerns	___	___

Musculoskeletal	No	Yes
Joint pain	___	___
Joint stiffness	___	___
Muscle pain	___	___
Back pain	___	___

Skin	No	Yes
Rash	___	___
Itching	___	___
Suspicious lesions or spots	___	___
Hair loss	___	___

Neurologic	No	Yes
Frequent headaches	___	___
Localized weakness	___	___
Numbness	___	___
Lightheaded or dizzy	___	___
Loss of consciousness	___	___

Psychiatric	No	Yes
Depression	___	___
Frequently sad or blue	___	___
Loss of interest in activities	___	___
Anxiety/nervousness	___	___

Endocrine	No	Yes
Excessive thirst or urination	___	___
Heat or cold intolerance	___	___

Hematologic/Lymphatic	No	Yes
Easy bruising or bleeding	___	___
Enlarged glands or lumps	___	___

Allergic/Immunologic	No	Yes
Hay fever	___	___
Hives	___	___
Food allergies	___	___