

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 Mississippi 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 Northwest MS Otolaryngology 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

- | | | |
|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Dementia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Exposed to Fumes, Dust, Solvents | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding/Blood Problem | <input type="checkbox"/> Headaches | <input type="checkbox"/> Otitis Media, Chronic |
| <input type="checkbox"/> Cancer What kind? _____ | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Cancer |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |

Prior Surgeries

- | | |
|--|-------|
| <input type="checkbox"/> Appendectomy | _____ |
| <input type="checkbox"/> Cholecystectomy (Gallbladder) | _____ |
| <input type="checkbox"/> Coronary Artery Bypass Grafting | _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Mastectomy | _____ |
| <input type="checkbox"/> Parathyroidectomy | _____ |
| <input type="checkbox"/> Sinus Surgery | _____ |
| <input type="checkbox"/> Thyroidectomy | _____ |
| <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Ear Tubes | _____ |
| <input type="checkbox"/> Adenoidectomy | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

What year?

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?
- _____

Cardiology

- Do you take any blood thinners? **Yes No**
- Are you under the care of a cardiologist?
- Yes No**
- Have you fallen in the last 12 months? **Yes No**

Social History

- | | | |
|---|--|------------------------------|
| Do you currently use tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How much? _____ |
| In the past, did you use tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Quit date? _____ |
| Are you around smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you drink Alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How many drinks daily? _____ |
| Do you currently use illegal drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, what kind? _____ |
| In the past, did you use illegal drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, what kind? _____ |

Family History

- | | | |
|--|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Dementia | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Exposed to Fumes, Dust, Solvents | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Otitis Media, Chronic |
| <input type="checkbox"/> Bleeding/Blood Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer What kind? _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Other: _____ | |

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	Genitourinary	No	Yes
Recent weight change	___	___	Frequent urination	___	___
Fever/chills/night sweats	___	___	Burning or painful urination	___	___
Fatigue	___	___	Incontinence or dribbling	___	___
Sleep problems	___	___	Trouble initiating stream	___	___
Loss of appetite	___	___	Weak urine stream	___	___
			Sexual difficulty or concerns	___	___
Eyes	No	Yes	Musculoskeletal	No	Yes
Vision difficulty	___	___	Joint pain	___	___
Concerns about eyes	___	___	Joint stiffness	___	___
Ears/Nose/Throat	No	Yes	Muscle pain	___	___
Hearing difficulty	___	___	Back pain	___	___
Sinus problems	___	___	Skin	No	Yes
Nose or throat concerns	___	___	Rash	___	___
Cardiovascular	No	Yes	Itching	___	___
Chest pain	___	___	Suspicious lesions or spots	___	___
Palpitations/irregular heart beat	___	___	Hair loss	___	___
Shortness of breath while lying flat	___	___	Neurologic	No	Yes
Swelling of legs	___	___	Frequent headaches	___	___
History of heart murmur	___	___	Localized weakness	___	___
Rheumatic heart disease	___	___	Numbness	___	___
Respiratory	No	Yes	Lightheaded or dizzy	___	___
Frequent cough	___	___	Loss of consciousness	___	___
Coughing up blood	___	___	Psychiatric	No	Yes
Shortness of breath	___	___	Depression	___	___
Wheezing	___	___	Frequently sad or blue	___	___
History of TB	___	___	Loss of interest in activities	___	___
History of asthma	___	___	Anxiety/nervousness	___	___
History of pneumonia	___	___	Endocrine	No	Yes
Gastrointestinal	No	Yes	Excessive thirst or urination	___	___
Abdominal pain	___	___	Heat or cold intolerance	___	___
Heartburn	___	___	Hematologic/Lymphatic	No	Yes
Change in bowel patterns	___	___	Easy bruising or bleeding	___	___
Blood in stool	___	___	Enlarged glands or lumps	___	___
Black tarry stool	___	___	Allergic/Immunologic	No	Yes
Nausea	___	___	Hay fever	___	___
Vomiting	___	___	Hives	___	___
Frequent diarrhea	___	___	Food allergies	___	___
Constipation	___	___			
Trouble swallowing	___	___			
History of ulcers, gallstones	___	___			