Carolina Pines ENT
2032 Medical Park Dr., Newberry, SC 29108
Phone: (803) 630-5353 Fax: (803)630-5343

TO COMPLETE YOUR FORM:
• Fill out all applicable sections
• Resave file with a unique name
• Email your resaved form to info@carolinapinesent.com

THANK YOU FOR CHOOSING CAROLINA PINES ENT

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Gender: · Male · Female · Other

Patient's Social Security Number: _____

Mailing Address: _____

City: _____ County: _____ Zip: _____

Cell Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Primary Email Address: _____

Marital Status: · Married · Single · Separated · Divorced · Widowed

Name of Spouse: _____

If a minor: **Father's Name**: _____ **Mother's Name**: _____

If the patient is a minor child and the parents are legally separated or divorced, please complete the following:

Which parent has legal custody of the minor child? _____

Which parent is financially responsible for the minor child's medical expenses after insurance? _____

Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

RESPONSIBLE PARTY

· You may check here if the responsible party is the same as the patient.

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security Number: _____

City: _____ Zip: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Gender: · Male · Female · Other

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RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Carolina Pines ENT. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer by protected be federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of patient or representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your health care and/or payment for your health care provided at Carolina Pines ENT?

· I may be contacted by any method

If not any method, contact me by *(check all that apply)*: · Home Phone · Cell Phone · Work Phone · Mail · Email

May we leave a message on your answering machine/voicemail? · Yes · No

Of the selected preference or preferences above, what is your preferred method of contact or how you like to be contacted first?

· Home Phone · Cell Phone · Work Phone · Mail · Email

HIPAA RELEASE OF INFORMATION *(please choose an option below)*

· **OPTION 1:** **HIPAA DELEGATES:** I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my health care and/or payment for my health care provided at Carolina Pines ENT.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

· **OPTION 2:** **HIPAA DELEGATES:** I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. In an emergency, you may contact my emergency contacts below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

· **OPTION 3:** **MINOR PATIENT RELEASE:** I authorize the following individual(s) to consent to medical treatment in my absence.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient/Parent Signature: _____ Date: _____

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Patient Name: _____

PRIMARY INSURANCE INFORMATION *(Please provide copies of any insurance cards)*

Name of Primary Insurance: _____ ID Number: _____

Group Number: _____ Co-Pay Amount: _____ Effective Date: _____

Subscriber information *(Person who carries the insurance)* ・Check here if same as patient.

Name: _____ DOB: _____

Mailing Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____

SECONDARY INSURANCE INFORMATION *(Please provide copies of any insurance cards)*

Name of Primary Insurance: _____ ID Number: _____

Group Number: _____ Co-Pay Amount: _____ Effective Date: _____

Subscriber information *(Person who carries the insurance)* ・Check here if same as patient.

Name: _____ DOB: _____

Mailing Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____

FINANCIAL POLICY

This information is to provide clarification for patients of Carolina Pines ENT regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Carolina Pines ENT has an obligation to various health care plans to apply any deductible and/or collect any co-payment prior to provision of service.

Co-Pays: You will be required to pay your co-payment upon arrival for your appointment.
Deductibles and Co-Insurance: You will be asked at check-in or check-out for any deductible or co-insurance that may be applicable to your office visit.
Previous Balances: You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Billing Services.
Non-Covered Services: Charges for all non-covered services will be the responsibility of the patient. It is the responsibility of the patient to verify benefits with your insurance prior to services rendered.

You may be asked to present your insurance card at each visit.

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the Carolina Pines ENT financial policy and agree to the terms of the policy.

Patient/Parent Signature: _____ Date: _____

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Patient Name: _____

GENERAL Consent

The following are conditions for services provided by Carolina Pines ENT for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carolina Pines ENT.

ACKNOWLEDGEMENT OF PATIENT FOLLOW UP PLAN

Health care is a partnership in which the physician and the patient both have responsibilities. It is the physician's responsibility, in consultation with you, to arrive at a diagnosis, keep you informed of your diagnosis, identify treatment options and explain the importance of any recommended follow-up. Once the diagnosis and course of treatment have been established and agreed upon collaboratively, it is the patient's responsibility to follow the agreed-upon treatment plan and to return as advised for ongoing assessments of health, illness and treatment outcomes.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient, and I/we assign my/our rights in any insurance benefits or other funding to the physician and Carolina Pines ENT. I/we understand that I/we am/are

responsible for any charges not covered by insurance or other forms of benefits.

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Carolina Pines ENT on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the

Social Security Act.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we was/were offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.carolinapinesent.com

CONTACTING PATIENTS

I hereby authorize Carolina Pines ENT to contact me through the information provided at the time of registration.

DISCLOSURE/USE OF HEALTH INFORMATION

I understand that uses and disclosures of my personal and health information are described in Carolina Pines ENT's Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an

insurance company or other payor (such as Medicare) to process payment for my care.

PHOTOGRAPHING

I consent to Carolina Pines ENT taking photographs for purposes of identification. Photographs that could identify me will only be used for internal medical record identification purposes.

Patient/Parent Signature: _____ Date: _____

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PATIENT HEALTH HISTORY AND PHYSICAL FORM

REFERRING/PRIMARY CARE DOCTOR: _____

PHARMACY: _____

REASON FOR VISIT TODAY: _____

WHAT ARE YOUR CURRENT SYMPTOMS? *(Please check all that apply)*

- ☐ Ear infection
- ☐ Dizziness
- ☐ Recurring sore throat
- ☐ Swallowing difficulty
- ☐ Nasal blockage
- ☐ Enlarged glands
- ☐ Coughing up blood
- ☐ Drainage from ears
- ☐ Hearing loss
- ☐ Strep throat
- ☐ Sore in mouth
- ☐ Sinus trouble
- ☐ Strange odor or taste
- ☐ Bleeding gums
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Hay fever/seasonal allergies
- ☐ Cough
- ☐ Growth and neck/throat
- ☐ Other: _____

PEDIATRIC: Immunizations Up To Date: · Yes · No Flu Shot: · Yes · No

Passed Newborn Hearing Screening: · Yes · No Meeting all developmental milestones: · Yes · No

WHAT OTHER MEDICAL PROBLEMS DO YOU/HAVE YOU HAD? *(Please check all that apply)*

- ☐ Stroke
- ☐ Nervous disorders
- ☐ TIA
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Asthma
- ☐ COPD
- ☐ Kidney failure
- ☐ Bleeding disorders
- ☐ Cancer:

What Type: _____

- ☐ High cholesterol
- ☐ Problems with anesthesia
- ☐ Autoimmune disease

What Type: _____

- ☐ Other: _____

_____

WHAT ARE YOUR DRUG/MEDICATION ALLERGIES?

· No Known Drug Allergies · Penicillin · Sulfa · NSAIDS · Morphine · Aspirin · Tape · Latex · Contrast Dye

· Insect Stings/Bites · Others: _____

Foods: _____

SURGERIES AND HOSPITALIZATIONS:

Problems With Anesthesia: _____

Past Surgeries: _____

_____

Past Hospitalizations for Non-Surgical Reasons: _____

_____

Past Non-Surgical Treatments (Chemo or Radiation): _____

_____

Serious Injuries: _____

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SOCIAL HISTORY:

Tobacco: · Current every day smoker · Current some-day smoker · Former smoker · Never smoker

· Current smokeless tobacco user · Former smokeless tobacco user · Vape

If yes, how many years? _____ How much do you use in a day: _____ When did you quit? _____

Do you consume alcohol? · Yes · No If yes, how much alcohol do you use on a regular basis? _____

Do you currently use any illicit drugs including marijuana, cocaine, methamphetamine, heroin, or other street drugs? · Yes · No

WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY? *(Please check all that apply)*

- ☐ Stroke
- ☐ Nervous disorders
- ☐ TIA
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Asthma
- ☐ COPD
- ☐ Kidney failure
- ☐ Bleeding disorders
- ☐ Cancer

What type: _____

- ☐ High cholesterol
- ☐ Problems with anesthesia
- ☐ Autoimmune disease

What type: _____

- ☐ Other: _____

REVIEW OF SYSTEMS: *(PLEASE CIRCLE ALL THAT CURRENTLY APPLY TO THE PATIENT)*

Constitutional:

• Fevers • Chills • Night sweats • Unexplained weight loss

ENT:

• Hearing Changes • Ear pain • Nasal Congestion • Sinus Pain • Hoarseness • Sore throat, • Runny Nose •Swallowing Difficulty

Eyes:

• Eye Pain, • Swelling, • Redness, • Foreign Body, • Discharge, • Vision Changes

Cardiovascular:

• Chest Pain, • Shortness of breath, • Difficulty Breathing on Exertion, • Palpitations

Respiratory:

• Cough, • Sputum, • Wheezing, • Smoke Exposure, • Difficulty breathing

Gastrointestinal:

• Nausea, • Vomiting, • Diarrhea, • Constipation, • Pain, • Heartburn, • Jaundice

Genitourinary:

• Pain with urination, • Urinary Frequency, • Blood in the urine, • Urinary Incontinence, • Urgency

Musculoskeletal:

• Joint pain, • Muscle pain, • Joint Swelling, • Joint Stiffness, • Back Pain, • Neck Pain

Skin:

• Skin Lesions, • Itching • Hair Changes, • Breast/Skin Changes

Neuro:

• Weakness, • Numbness, • Loss of Consciousness, • Dizziness, • Headache

Psych:

• Anxiety/Panic, • Depression, • Insomnia, • Personality Changes,

Heme/Lymph:

• Bruising, • Bleeding, • Transfusions History, • Lymph node enlargement

Endocrine:

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• Frequent urination, • Increased thirst, • Temperature Intolerance

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids), vitamins (examples: vitamin D, calcium) and herbals (examples: ginseng, gingko) Include medicines taken as needed (example: nitroglycerin)

Name of Medication & Dose	Directions (No. of times a day)	Reason For Taking	Date Stopped
Example: Coumadin 5 mg	One pill daily	Blood clots	

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Carolina Pines ENT & Allergy Associates notice of privacy practice.**

Patient/Parent Signature: _____ Date: _____