PLEASE FILL OUT AND PRINT THIS DOCUMENT THEN BRING IT WITH YOU TO YOUR APPOINTMENT

ADVANCED
OTOLARYNGOLOGY & AUDIOLOGY

Today's Date: ____/____/____

Patient Information:

Last name: _____ First Name: _____ MI: _____ Age: _____

Social Security Number: _____-_____-_____ DOB: _____/_____/_____ Gender: Male / Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone :(_____) _____-_____ Cell Phone :(_____) _____-_____ Marital Status: _____

Email address: _____

Employer's name_____ Phone Number :(_____) _____-_____

Insurance/Policy Holder Information: (**MUST BE FILLED OUT**)

If the information below is not provided as requested by our office then you will be billed as self-pay.

PRIMARY INSURANCE	SECONDARY INSURANCE
INS CO._____	INS CO._____
Subscriber: _____	Subscriber: _____
D.O.B.: _____	D.O.B.: _____
Employer: _____	Employer: _____
I.D. #: _____	I.D. #: _____
Group #: _____	Group #: _____
Relationship to Patient: _____	Relationship to Patient: _____

If policy holder address is different from above please provide: _____

Designation of Care Giver for Communication of Protected Health Information and Emergency Contact

At my request, I authorize the person(s) below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this person(s) may inquire about the child's personal health and/or billing information and, if necessary, bring the child to appointments on my behalf.

Name	Relationship	DOB	Phone Number	Emergency Contact
				YES or NO
				YES or NO
				YES or NO

ADVANCED
OTOLARYNGOLOGY & AUDIOLOGY

In order for us to obtain a complete medical history, it is important for you to fill out this form to the best of your knowledge. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into our computer and you are welcome to a copy of the report if you wish.

Full Name: _____ DOB: ___/___/___ Current Date: ___/___/___

Pharmacy (list location):_____ Lab: _____

Did another physician refer you to us? (If so please tell us who) _____

Name & Location of Primary Care Doctor: _____

Current Height: _____ Current Weight: _____ Use of tobacco products ☐ Yes ☐ No If Yes, Form: _____ Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks per week? _____

Current Medication (this includes prescription, over the counter or herbal medications)

Medication Name	Dosage	How often taken

Any previous Illness: _____

Are you allergic to any medications? Yes ☐ No ☐ If Yes, please list the names of all the medications:

_____

Have you had any previous surgeries or procedures: Yes ☐ No ☐ If Yes, Please list below.

Type of surgery or procedure	Date

Family history: Please list any diseases that run in the family and who has the disease:

What is the reason for your visit today? _____

How long have you been experiencing this problem? _____

ADVANCED
OTOLARYNGOLOGY & AUDIOLOGY

Patient Name: _____ DOB: ___/___/___ Current Date: ___/___/___

Please circle any of the following signs or symptoms you may have.

GENERAL
Fever
Chills
Sweats
Weight loss
Weight gain

SKIN
Itching
Bruising
Bleeding
Non- healing sores
Pigmentation change

MUSCULOSKELETAL
Arthritis
Muscle Inflammation
Joint swelling
Joint Stiffness
Muscle weakness

RESPIRATORY SYSTEM
Painful breathing
Shortness of breath
Wheezing
Awakening short of breath
Cough
Sputum or blood with coughing

CARDIOVASCULAR SYSTEM
Palpitations
Fast Heart Rate
Irregular Heart Rate
Chest Pain
Leg Swelling

NERVOUS SYSTEM
Paralysis
Incoordination
Difficulty Speaking
Numbness
Tingling
Staggering
Vision Changes

ENDOCRINE SYSTEM
Weakness
Goiter
Skin or Hair dryness
Heat or Cold
Intolerance
Excessive appetite
Excessive drinking

ALLERGY/IMMUNOLOGY
Dermatitis
Hives
Eczema
Hay Fever

GENITOURINARY SYSTEM
Change in urine color
Painful urination
Bloody urine
Frequent urination
Incontinence
Stones

GASTROINTESTINAL SYSTEM
Swallowing problems
Nausea
Vomiting
Abdominal pain
Jaundice
Rectal Bleeding
Black or Bloody Stools

HEAD/NECK
Headaches
Migraine
Seizures
Fainting
Visual loss
Double vision
Deafness
Vertigo
Ear Drainage
Ear pain
Nasal Drainage
Nasal Blockage
Hoarseness
Neck stiffness/pain

Patient Name: _____ DOB: 2___/___/___ Current Date: ___/___/___

All Insurance Plans and Self Pay

I hereby instruct my insurance company to pay benefits directly to ADVANCED OTOLARYNGOLOGY and AUDIOLOGY PC, 2001 S. Shields St. Suite E #101, Fort Collins, CO, 80526-1827

Should there be a referral required from your insurance plan and has not been obtained at the time of service, you agree to pay in full any charges incurred.

Medicare:

I request that payment of authorized Medicare benefits be made to Advanced Otolaryngology & Audiology P.C., on my behalf for any services provided or performed by or in Advanced Otolaryngology and Audiology, P.C., including all of the physician services. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents, which is needed to determine these benefits for related services.

I authorize the release of necessary information to any insurance company, adjuster, or attorney involved.

I understand that payment for all services is my responsibility, including SELF-PAY patients. I agree to pay any balance over and above the insurance payment.

Authorized Patient or Guarantor Signature:

_____

Print Name of Authorized Patient or Guarantor:

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health care information may be used as necessary to support the day to day activities and management of **Advanced Otolaryngology, P.C.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

ADVANCED
OTOLARYNGOLOGY & AUDIOLOGY

Individual Rights

You have certain rights under the federal privacy standards. These include:

- **The right to request restrictions on the use and disclosure of your protected health information**
- **The right to receive confidential communications concerning your medical condition and treatment**
- **The right to inspect and copy your protected health information**
- **The right to amend or submit corrections to your protected health information**
- **The right to receive an accounting of how and to whom your protected health information has been disclosed**
- **The right to receive a printed copy of this notice**

Advanced Otolaryngology, P.C. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or privacy officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Advanced Otolaryngology, P.C.
2001 S. Shields, Bldg. E #101
Fort Collins, Colorado 80526

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice was updated 7/26/12

I understand that this information is necessary to provide me, my child/children or persons I am legally responsible for, with medical care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. I understand it is my responsibility to advise the office of any changes in the information contained on all forms.

_____ ___/___/___

Signature of patient or legal guardian **Date**