

Jay B. Farrior, M. D.
Ear Surgery & Neurotology

Board Certified 1981
Best Doctors in America since 1989
Clinical professor - USF Dept. Oto-HNS
American Otologic Soc.
American Neurotologic Soc.
Triologic Soc.
American Academy Otolaryngology HNS
AMA, FMA, SMA, HCMA

Bart Baker, M.S., CCC-A
Audiology, Hearing Aids



HEARING & BALANCE

Established 1947
In Memory of
J. Brown Farrior, M.D. 1881 - 1931
Otolaryngology
Brown Farrior, M. D. 1911 - 1995
Otology - Ear Surgery

2727 W. Martin Luther King Blvd.
Suite 520
Tampa Florida, 33607, USA
Ph. 813-879-0810
800-342-3277
Fax 813-879-8037

**PLEASE READ
TO ALL OUR PATIENTS
PLEASE DO NOT MAIL BACK.**

Due to the frequency with which patients change their insurance carriers, you must present your insurance card and driver's license when you come to the office. We will verify your address and telephone number as well. If there is any change please notify the receptionist.

Only with the help of our patients by submitting the correct information, on the day of your appointment, errors in filling insurances will most likely be avoided.

We realize that you have a busy schedule and we will make every effort to see you as quickly as possible. Because most of our patients have some form of hearing loss, a detailed hearing test is obtained on the day of your visit before seeing Dr. Farrior. During your visit he will want to review your history of ear problems and perform a thorough examination. The time required for the examination varies with each individual.

We cannot anticipate the exact amount of time required to evaluate and answer all questions that you may have, so as a result, your visit may take up to 1 to 3 hours. We appreciate your patience and understanding.

We would also appreciate it if you have your primary care and/or referring physician's information available with you.

We sincerely THANK YOU for your cooperation in helping us give you the best services and care.

FARRIOR EAR CLINIC

SIGNATURE

DATE

New Patient Information
Please Fill Out Completely and Thoroughly.

Patient Information:

Name: _____ Date of Birth: ____/____/____ Age: _____

S. S. # ____/____/____ Home Ph: (____)-____-____ Work Ph: (____)-____-____

Address: _____ Suite/Apt.# _____ City _____ State _____ Zip _____

Sex: Male / Female Marital Status: M S D W Employed? Yes / No

Name of Employer: _____ Phone Number: (____)-____-____

Emergency Contact: _____ Phone number: (____)-____-____

Primary Physician: _____ Phone Number: (____)-____-____

Address: _____ Suite#: _____ City: _____ State: _____ Zip _____

Reason for Visit Today:

Insurance Information: PRIMARY

Insurance Name: _____ HMO PPO POS PRIVATE SELF PAY

Policy/ID/Claim#: _____ Group#: _____

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

Eligibility/Membership Phone Number: (____)-____-____

Primary Person on Insurance: SELF SPOUSE PARENT OTHER

Name: _____ S.S. #: ____/____/____ Date Of Birth: ____/____/____

Sex: Male / Female Employers Name: _____ PH: (____)-____-____

SECONDARY INSURANCE:

Insurance Name: _____ HMO PPO POS PRIVATE SELF PAY

Policy/ID/Claim#: _____ Group#: _____

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

Eligibility/Membership Phone Number: (____)-____-_____

Primary Person on Insurance: SELF SPOUSE PARENT OTHER

Name: _____ S.S. #: ____/____/____ Date Of Birth: ____/____/____

Sex: Male / Female Employers Name: _____ PH: (____)-____-_____

***** Please make sure to give the receptionist your insurance cards and a photo ID. *****

VERY IMPORTANT FOR ALL PATIENTS

I certify that the information I submitted to FARRIOR EAR CLINIC is correct and up to date. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balances of my account for any services rendered.

I will notify the office of any changes in my health or the information provided.

Your records may be reviewed for scientific presentations by Farrior Ear Clinic staff or Resident Doctors.

In additions, a resident doctor may see you as part of medical training.

If your insurance requires you to have a referral or authorization, and if you do not have the authorization or referral and our office has not received it via fax or mail; you will have to reschedule your appointment.

Signature (Parent/Guardian)

_____/_____/_____
Date

HIPPA PRIVACY POLICY
EFFECTIVE APRIL 1, 2003

This office may not use or disclose your Personal Health Information (PHI) without your permission except in cases permitted by law.

- 1) We may use or disclose your Personal Health Information (PHI) in order to provide you with services and treatment you required or request.
- 2) We may use or disclose your PHI in order to collect payments for those services.
- 3) We may use or disclose your PHI information in order to conduct health care operations otherwise permitted or required by law.
- 4) We are permitted to disclose your PHI within and among our facility and staff in order to accomplish this same purpose.
- 5) We may use or disclose your PHI to Resident Doctors or Lectures per request of Doctor Farrior.

Except as otherwise permitted or required, as describe above, we may not use or disclose your PHI without your written authorization. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke this specific authorization at any time.

_____ I, _____, **DO NOT** grant permission for my health care management to be discussed with anyone other than my self.

_____ I, _____, **DO** grant permission for my health care management to be discussed with the following person(s):

- 1.) _____ Relationship _____
- 2.) _____ Relationship _____
- 3.) _____ Relationship _____

Physician's _____

Address and phone number

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

In general, the HIPAA privacy rule allows an individual the have the right to request a restriction on the uses and disclosures of their Protected Health Information (PHI).The Individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office or via fax instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone: _____ | <input type="checkbox"/> Written Communications |
| <input type="checkbox"/> O.K. to leave a message with detailed Information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave Message with call-back number | <input type="checkbox"/> O.K. to mail to my work address |
|
 | |
| <input type="checkbox"/> Work Telephone: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | _____ |
| <input type="checkbox"/> Leave Message with call-back number | _____ |

**Please list below the name(s) of individual(s) you authorized our office
To discuss your Personal Health Information (PHI) with including all
physicians:**

If you have any question regarding you health care information or our privacy policy,
please feel free to call Vanessa Diaz, 813-879-0810.

**THANK YOU
FARRIOR EAR CLINIC**

TELL ME ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY

NAME: _____ Date of Birth: ____/____/____

Check any medications listed below that which you are allergic to:

No Known Allergies

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Erythromycin	OTHER: _____
<input type="checkbox"/> Betadine/ Iodine	<input type="checkbox"/> Morphine	_____
<input type="checkbox"/> Cipro Ear Drops	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Cortisporin Ear Drops	<input type="checkbox"/> Tetracycline	_____

What medications are you currently taking? Please include both prescription and non-prescription medications.

Check any of the medical problems listed below that you have now:

I have no known medical problems

<input type="checkbox"/> Adult Onset Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tinnitus (ringing in ear)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Childhood Onset diabetes	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Vertigo (dizziness)
<input type="checkbox"/> COPD/ Lung Problem	<input type="checkbox"/> Overweight	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Past Heart Attack	_____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Peripheral Vascular Disease	_____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Thyroid Disease	

Surgical History Type: _____ Date: _____

Ear and Hearing History

Name _____

Date _____

Please Mark the appropriate answers, Please give a detailed description of all positive answers

Primary problem: Hearing Loss ____, perforated eardrum ____, Cholesteatoma ____, Dizziness/vertigo ____, Infection ____, Ear pain ____

Other _____

Description:

Pervious ear infections: No ____, Yes ____

Previous ear surgery: No ____, Yes ____

Ear pain, pressure, itching: No ____, Yes ____,

Hearing loss: None ____, Yes ____, Right ____, Left ____, both ____, Recent ____, Sudden ____, Fluctuating or changing ____,

Gradual ____, over months ____ or years ____,

Cause _____

Noise exposure: No ____, Yes ____, Source

Family History - Hearing Loss: No ____, Yes ____, Relationship / cause

Tinnitus (Ringing): No ____, Yes ____, Right ear ____, Left ear ____, Both ____, Ringing ____, Roaring ____, Pulsating ____, Popping or clicking ____, Duration _____ wks., mos. yrs.

Vertigo, Dizziness: No ____, Yes ____, Spinning / whirling ____, Light headed ____, Faint ____, Blackout ____, Falling ____, Stagger ____, trouble walking ____,

Description _____

Duration of spells: min. ____, hrs. ____, days ____, constant ____,

Frequency: rare ____, per year ____, per month ____, per week ____, daily ____, constant

Precipitating events: none ____, movement ____, laying down ____, getting up ____, turning __ R ____, L ____, stress ____, walking ____, riding in a car ____, Other

Associated symptoms; nausea ____, vomiting ____, hearing loss ____, numbness ____, weakness ____, other

Most recent attack: Date _____, Duration _____ min., hr., days,, nausea ____, vomiting _____

Description:

What had you eaten in the 2 days before the attack:

Medical / Surgical: High blood pressure ____, Stroke/ TIA ____, Heart attack ____, vascular disease ____, Asthma ____, Emphysema ____, Short of breath ____, Allergy ____, Anemia ____, Nasal congestion ____, Arthritis ____, Bad knees ____, bad hip ____, visual ____, bifocal glasses ____, Brain tumor ____, cancer ____, Heart surgery ____, Vascular surgery, Joint replacement surgery ____, Neck /back surgery __

Describe positive

Medication & disorder

Additional history pertaining to your problem & visit

FARRIOR EAR CLINIC
Tampa Medical Tower
2727 W. Martin Luther King Blvd.
Suite 520
Tampa, Florida 33607
East of St. Joseph's Hospital
Ph. 813-879-0810 / Fax 813-879-8037
Main Entrance- Turn right off of MLK into Tampa Medical Tower
Additional parking behind building,
2nd Entrance off of Habana. Just north of Chevron Station.

South Tampa

North on Howard to Armenia to MLK Blvd. - Left on MLK 2 blocks to Tampa Medical Tower-
Right into parking lot.

North Macdill, or Dale Mabry to MLK- Right on MLK to Habana- Left on Habana, immediate
Right into Tampa Medical Tower Parking, just North of Chevron Station

North Tampa

South on Dale Mabry to MLK- Left on MLK to Habana- Left on Habana- Right into Tampa
Medical Tower parking lot, Just north of Chevron Station

I-275 south to MLK, Exit 46A- Turn right on to MLK going west- 2 miles to Tampa Medical
Tower. Right into lot

Brandon, Sun City

I-75 North to I-4, West on I-4 to I-275, North on I-275, Exit MLK (exit #46B), Turn Left on
MLK going West- 2 miles to Tampa Medical Tower. Turn right into parking lot.

Clearwater

Hwy 60 East to Tampa

-Left on Kennedy Blvd. to Dale Mabry – Left on Dale Mabry past Stadium to MLK –
Right on MLK to Habana – Left on Habana – Immediately turn Right into Tampa, Medical
Tower, North of Chevron Station

-Left on Kennedy Blvd. to Howard Ave Left on Howard Ave Merges with Armenia –
Turn Left on MLK 2 blocks Tampa Medical Tower – Right into Tampa Medical Tower parking

Tarpon Springs, New Port Richey

US 19 south to Tampa Rd. (CR. 752) east on Tampa Rd (Hillsborough Ave/ Fl 580) or Veteran's
Expressway south to Hillsborough Ave- East on Hillsborough Ave to Armenia – Right (south)on
Armenia to MLK – Right (west) on MLK 2blocks to Tampa Medical Tower – Right in Parking
lot

St. Petersburg

I-275 east to Tampa , Exit Dale Mabry North (Exit 41A) – North on Dale Mabry past Stadium to
MLK – Right on MLK to Habana - Left on Habana immediately turn right in Tampa Medical
Tower parking lot, just north chevron station.

Lakeland, Orlando

I-4 West to Tampa I-275 North – I 275 North -1 mile to MLK (Exit 46B) – Turn left on MLK – 2
miles to Tampa Medical Tower- Turn Right into parking lot

Sarasota

I-75 North to I-4, I-4 west to I-275, I-275 North 1 mile to MLK (exit 46B), Turn left on MLK – 2
Miles to Tampa Medical Tower- Turn Right into Parking lot

Brooksville, Ocala

I-75 South to I-275, Veer Right onto I-275 to MLK – Exit MLK (Exit 46A) – Turn Right on to MLK – 2 miles to Tampa Medical Tower – Turn Right into Parking lot