

Jay B. Farris, 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

Farris
Ear
Clinic
Hearing & Balance

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

2727 W. Martin Luther King Blvd.
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Tampa Florida, 33607, USA

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Please do not mail back!
PLEASE READ TO ALL OUR PATIENTS

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 filing 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. Farris. 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; if you do not notify our office at the time your appointment is made of any dizziness, off-balance, or light-headed symptoms, you will be rescheduled.

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

Please Fill Out Completely

Patient Information:

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

S. S. # ____/____/____ Home Ph: (____)-____-____ Cell Phone (____)-____-____

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

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

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

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

Who referred you to Farris Ear Clinic: _____?

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

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

Reason for Visit Today:

***** 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 Farris Ear Clinic staff or Resident Doctors. In addition, 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

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: (_____) - _____ - _____

HIPPA PRIVACY POLICY

EFFECTIVE APRIL 1, 2008

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 described 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 PROMISSION** for my health care management to be discussed with anyone other than my self.

_____ I, _____, **DO GRANT PROMISSION** 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 of your physician(s).

How may we contact you?

| | |
|---|-------------------------------------|
| _____ Home Telephone: _____ | _____ Written Communications |
| ___ O.K. to leave a message with detailed Information | ___ O.K. to mail to my home address |
| ___ Leave Message with call-back number | ___ O.K. to mail to my work address |
| _____ Work Telephone: _____ | _____ Other: _____ |
| ___ O.K. to leave message with detailed information | _____ |
| ___ Leave Message with call-back number | _____ |

Signature: _____ **Date:** _____

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,**
_____ **Allergies:** _____

What medications are you currently taking? Please include both prescription and non-prescription medications. **Medications/ disorder:**

Occupation -Present/Past _____

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

_____ I have no known medical problems _____ Good health

Tobacco – Type _____ amount _____/day _____yrs.

Alcohol - Type _____ amount _____

- | | | | |
|-------------------------|------------|-------------------------|-----------------------|
| ___ Weight | ___ change | ___ Shortness of breath | ___ Nasal/sinus |
| ___ Diabetes | | ___ COPD/emphysema | ___ Allergy |
| ___ Thyroid | | ___ Asthma | ___ Vertigo/dizziness |
| ___ Tuberculosis | | ___ Ulcer | ___ Tinnitus/ringing |
| ___ Hepatitis | | ___ Acid reflux | ___ Stroke/TIA |
| ___ HIV/Aids | | ___ Gall Bladder | ___ Numbness/weakness |
| ___ Heart/cardiac | | ___ Liver | ___ trouble walking |
| ___ Heart attack | | ___ Kidney/Bladder | ___ Anemia |
| ___ Arrhythmia | | ___ Neck/Back Problems | ___ Bleeding |
| ___ Vascular problems | | ___ Muscle Problems | ___ Tumors/cancer |
| ___ High Blood pressure | | ___ Arthritis/Joint | |
| ___ Immune disorders | | | |

Others: _____

Family History

List any and all Surgeries and dates when they were preformed:

***Please place any additional information on the back of this page. ***5/7

EAR AND HEARING HISTORY
THIS PAGE MUST BE FILL OUT IN ITS ENTIRETY

Name _____ Date of Birth _____

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 ____, Ringing in the ear: ____ Right, ____ Left, or ____ Both

How long has it been? _____ Hours; _____ Days; _____ Months; _____ other.

IF YOU CHECKED ONE OF THE ABOVE PROBLEMS PLEASE DESCRIBE: _____

Previous Problems (PLEASE NOTE IF THIS OCCURRED IN YOUR YOUTH OR AS AN ADULT):

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

Ear infections: No ____, Yes ____ As a Child: _____ As a Adult: _____

Please describe symptoms: _____

Ear surgery: No ____, Yes ____ As a Child: _____ As a Adult: _____

What surgery did you have and when? _____

Who performed the procedure? _____

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

Please describe you symptoms: _____

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 ____,

Relation to family member cause of their hearing loss: _____

Tinnitus (Ringing): No ____, Yes ____, Right ear ____, Left ear ____, Both ____, Ringing ____, Roaring ____,

Pulsating ____, Popping or clicking ____, Duration _____ wks., _____ months, _____ years.

Describe symptoms and duration: _____

Additional history pertaining to your problem & visit

If you are having episodes of dizziness, lightheadedness, vertigo, and/or off-balance; please complete this page in its entirety.

Vertigo, Dizziness, Lightheadedness, Off-Balance, ECT..:

Are you dizzy, off-balance, lightheaded or anything that falls in the category of Vertigo? No ____, Yes ____,

What type of symptoms are you having? Spinning / whirling ____, Light headed ____, Faint ____, Blackout ____, Falling ____, Stagger ____, trouble walking ____,

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

Description of symptoms & duration of the spells: _____

How frequent are your dizzy spells? Constant ____, rare ____,; how many times per year _____?

How many times per month _____? How many times per week _____ or are they daily? ____ No, ____ Yes,

If the spells are daily how often during the day do you experience the symptoms _____?

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

Do you have any other associated symptoms with the dizzy spells? nausea ____, vomiting ____, hearing loss ____, numbness ____, weakness ____, other _____

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

Describe your episode: _____

What did you eat in the two days prior to your episode? _____
