

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, 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 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 myself.

_____ 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:** _____

UPDATE YOUR HISTORY

Today's date: _____

NAME: _____

Date of Birth: ____/____/____

We need to know what is new since your last visit here at Farrior Ear Clinic!

_____ No Known Allergies; **or** Allergies: _____

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

Medications/ disorder: _____

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

_____ I have no new, known medical problems. _____ Good health same 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:

Ear and Hearing History

Today's Date _____

Name _____

Date of Birth _____

Please Mark the appropriate changes and give a detailed description of all positive answers that have occurred in the time you have not been to our office.

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

Other ____. **How long has it been?** _____ hours; _____ days; _____ months; _____ other.

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

Previous Problems: Hearing Loss ____, perforated eardrum ____, Cholesteatoma ____, Infection ____, Ear pain _____, Other _____.

Ear infections: No ____, Yes _____ As a child _____ as an adult _____

Please describe symptoms: _____

Previous ear surgery only: No ____, Yes _____ as a child _____ as a adult _____

What surgery did you have? _____ and when? _____

Who preformed the procedure? _____

Ear pain, pressure, and 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 _____

Tinnitus (Ringing): No ____ Yes ____, Right ear ____, Left ear ____, Both ____, Ringing ____, Roaring ____, Pulsating ____, Popping or clicking ____, Duration _____ wks., _____ months, _____ years. **Describe symptoms and duration:** _____

Others Symptoms: _____

Signature

Date

INITIALS NO EPISODES OF DIZZINESS, VERTIGO, OR OFF-BALANCENESS HAS OCCURRED IN THE TIME I HAVE NOT BEEN INTO FARRIOR EAR CLINIC.

***If you are having episodes of Dizziness, Vertigo, Lightheadedness or Off-balance;
Please complete this page in its entirety.***

Vertigo, Dizziness, Lightheadedness, and/or Off-Balance:

Are you Dizzy, Lightheadedness, Off-balance 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? _____
