



Welcome to our office.
PLEASE USE BLACK INK – Thank you.

PERSONAL INFORMATION

Name (Please print) _____ Male [] Female [] Date ____/____/____
Street _____
City _____ State _____ Zip Code _____
Home Phone _____ Work/Cell phone _____
Email Address _____
Age _____ Date of Birth _____ Social Security Number _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____
Occupation _____ Employer _____
Parent/Guardian Name (if patient is under the age of 18) _____
Name of Nearest Relative not living with you _____
Address _____ Phone _____
Name of current primary care physician _____
How were you referred to us, if other than your primary care physician? _____
Please explain briefly the reason for your visit: _____

INSURANCE

Name of PRIMARY Insurance Company: _____
Policy ID# _____ Group Number: _____
Policy Holder's Name _____ Policy Holder's Birth Date _____
Policy Holder's Social Security Number _____ Relationship to you _____

Name of SECONDARY Insurance Company: _____
Policy ID# _____ Group Number: _____
Policy Holder's Name _____ Policy Holder's Birth Date _____
Policy Holder's Social Security Number _____ Relationship to you _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION:

I authorize the release of medical information necessary to process my claim. I authorize the payment of medical benefits to Integrated Ear, Nose & Throat for services rendered.

Signed: _____ Date: _____

Integrated Ear, Nose & Throat

NAME: _____ DATE: ___ / ___ / ___ BIRTHDATE: ___ / ___ / ___

WEIGHT: _____ HEIGHT: _____ AGE: _____

REFERRED BY: _____

REASON FOR VISIT (DESCRIBE PROBLEM): _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

	YES	NO		YES	NO
Abnormal Bleeding			High Cholesterol		
Allergy Testing/Treatment			HIV		
Anemia			Hives		
Asthma			Hypertension		
Autoimmune Disease			Hypotension		
Cancer			Meningitis		
Chronic Obstructive Pulmonary Disease			Migraine Headaches		
Diabetes			Nasal Trauma		
Ear Infection			Reflux/GERD		
Ear Pressure/Pain/Drainage			Sleep Apnea		
Hearing Loss			Thyroid Disorders		
Heart Murmur			Tinnitus/Ringing		
Hepatitis			Tuberculosis		
OTHER:			None <input type="checkbox"/>		

LIST ALL PREVIOUS SURGERIES: (Include tonsillectomy & adenoidectomy):

TYPE	DATE	TYPE	DATE
None <input type="checkbox"/>			

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Include over the counter & herbal supplements):

NAME	DOSAGE	NAME	DOSAGE
None <input type="checkbox"/>			

LIST ANY ALLERGIES (MEDICATIONS/LATEX/FOOD/INHALENTS/CHEMICALS)

None <input type="checkbox"/>		

FAMILY HISTORY (x) Diseases/Conditions YOUR FAMILY (Parents, grandparents, siblings, aunts & uncles) have had.

<input type="checkbox"/> None <input type="checkbox"/> Allergies – Who? _____ <input type="checkbox"/> Asthma – Who? _____ <input type="checkbox"/> Autoimmune Disease – Who? _____ <input type="checkbox"/> ENT Related Cancer – Who? _____ <input type="checkbox"/> Other Cancer – Who? _____	<input type="checkbox"/> Migraine Headaches – Who? _____ <input type="checkbox"/> Premature Hearing Loss – Who? _____ <input type="checkbox"/> Sinusitis – Who? _____ <input type="checkbox"/> Sleep Apnea – Who? _____ <input type="checkbox"/> Thyroid Disorders – Who? _____
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NAME: _____ BIRTHDATE: ____ / ____ / ____

SOCIAL HISTORY

LIST ANY HAZARDOUS MATERIALS YOU HAVE BEEN EXPOSED TO:

<input type="checkbox"/> None		
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CHECK WHICH APPLIES TO YOU:

<input type="checkbox"/> Alcohol Use <input type="checkbox"/> Never If yes, how much _____ per _____	Depressants <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Caffeine <input type="checkbox"/> Never If yes, how much _____ per _____	<input type="checkbox"/> Smoker <input type="checkbox"/> Never <input type="checkbox"/> Former If yes, how much _____ per _____	Stimulants <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chews Tobacco <input type="checkbox"/> Never If yes, how often _____	Marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other _____

DESCRIBE YOUR EXERCISE HABITS:

<input type="checkbox"/> Active but no formal exercise <input type="checkbox"/> Heavy Amount of Exercise (4 or more times per week) <input type="checkbox"/> Minimal Amount of Exercise (Once a week)
<input type="checkbox"/> Moderate (1 to 3 times per week) <input type="checkbox"/> Sedentary

MARITAL STATUS:

<input type="checkbox"/> Divorced <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed

REVIEW OF SYSTEMS

PLEASE CHECK YES (Y) OR NO (N) IF ANY SYMPTOMS ARE CURRENTLY PRESENT: (DO NOT LEAVE ANY BLANKS)

	Y	N		Y	N		Y	N		Y	N
General:			Cardiovascular:			Integument (skin)			Psychological:		
Fatigue			Chest pains			Rash			Anxiety		
Weight loss			Lightheadedness			Skin dryness			Depression		
Fever			Irregular heart beats			Hair growth change			Difficulty sleeping		
Body aches			Rapid heart rate			Changes to moles					
Weight gain						Nail changes			Hematology/Lymph		
Chills			Respiratory:						Easy bleeding		
Night sweats			Shortness of breath			Neurological:			Easy bruising		
			Hoarseness			Muscular weakness					
Eyes:			Wheezing			Memory difficulties			Allergic/Immunologic		
Double vision			Cough			Tingling/numbness			Sinus allergy symptoms		
Eye discomfort						Speech difficulties			Allergic dermatitis		
Blurred vision			Gastrointestinal:			Loss of balance			Frequent illnesses		
Changes in vision			Nausea								
			Excessive belching			Musculoskeletal:					
			Blood in stool			Joint pain					
HENT:			Vomiting			Joint swelling			<input type="checkbox"/> NONE		
Headaches			Heartburn			Muscle pain					
Ear Pain						Muscle cramps					
Vertigo			Genitourinary:								
Sinus pain			Pain on urination			Endocrine:					
Sore throat			Frequent urination			Heat intolerance					
Hearing loss			Kidney stones			Cold intolerance					
Nasal obstruction						Thyroid enlargement					
Ear discharge											



Financial Policy

Welcome to Integrated Ear, Nose & Throat, P.C. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information and any necessary referrals. Should your insurance require a referral, and we have not received it prior to your appointment, you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company.

Please sign below so that we may confirm that you have read and understand our office policy regarding insurance and your responsibilities as a patient of Integrated Ear, Nose & Throat, P.C.

Name (Please Print)

Date

Signature of Patient or Responsible Party

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Integrated Ear, Nose & Throat.

PATIENT NAME

DATE

PATIENT SIGNATURE

RELATIONSHIP TO PATIENT

(If signed by personal representative of Patient)

I authorize my Personal Health Information to be disclosed as specified below:

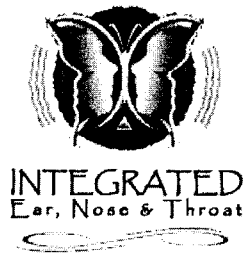
- On my voicemail/answering machine at my home phone number _____.
- On my voicemail/answering machine at my work/alternate number _____.
- To the following family member(s) or other person(s):

Name / Relationship / Phone Number

Name / Relationship / Phone Number

Signature of Patient or Authorized Person Representative

Date



DIAGNOSTIC SCOPES

We at Integrated Ear, Nose & Throat feel a patient presenting to our office with sinus, allergy, throat or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless and, in many cases, can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. In most cases we will accept your insurance company's allowance for this procedure. You will be obligated to pay only the deductible and/or co-payments that are applied to this claim. **(Please note:** Insurance companies will usually list this diagnostic procedure as "surgery" on the insurance remittance advice you receive.)

These procedures have almost no risk and provide your physician with an excellent view of the areas involved.

Name (Please Print)

Date

Signature of Patient or Responsible Party

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