CAREPOINTE EAR, NOSE, THROAT & SINUS CENTER

DATE _____

PATIENT INFORMATION - CHILD			
LAST NAME	FIRST NAME	MIDDLE INITIAL	HOME PHONE #
STREET ADDRESS	CITY	STATE/ZIP CODE	CELL PHONE #
DATE OF BIRTH / SOCIAL SECURITY # / SEX ○ MALE ○ FEMALE		EMAIL ADDRESS	
EMERGENCY CONTACT - NAME/PHONE #		HAS ANYONE IN YOUR HOUSEHOLD BEEN A PATIENT? ○ YES ○ NO RELATION	

PATIENT INFORMATION - FATHER			
LAST NAME	FIRST NAME	CELL # / PHONE #	DATE OF BIRTH
ADDRESS IF DIFFERENT	EMPLOYER NAME / PHONE #		SOCIAL SECURITY #

PATIENT INFORMATION - MOTHER			
LAST NAME	FIRST NAME	CELL # / PHONE #	DATE OF BIRTH
ADDRESS IF DIFFERENT	EMPLOYER NAME / PHONE #		SOCIAL SECURITY #

PRIMARY INSURANCE INFORMATION		
INSURANCE COMPANY NAME	POLICY ID #	POLICY GROUP #
SUBSCRIBER NAME	SUBSCRIBER ADDRESS	DATE OF BIRTH
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

SECONDARY INSURANCE INFORMATION		
INSURANCE COMPANY NAME	POLICY ID #	POLICY GROUP #
SUBSCRIBER NAME	SUBSCRIBER ADDRESS	DATE OF BIRTH
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

REFERRAL INFORMATION		
REFERRED BY	ADDRESS	CELL / PHONE #
FAMILY PHYSICIAN	ADDRESS	PHONE #

I AUTHORIZE THE FOLLOWING PEOPLE TO ACCOMPANY MY CHILD TO HIS OR HER APPOINTMENT IN MY ABSENCE:

NAME/RELATION/DOB: _____ NAME/RELATION/DOB: _____

NAME/RELATION/DOB: _____ NAME/RELATION/DOB: _____

PARENT SIGNATURE: _____ RELATION TO PATIENT: _____

*** **PLEASE NOTE, IF YOU ARE NOT THE MINOR PATIENTS PARENT, YOU MUST ATTACH PROOF OF GUARDIANSHIP*****

Consent to Share Confidential Medical/Billing Information

Patient's Legal Name: _____ Patient's Date of Birth: _____

I HEREBY AUTHORIZE CAREPOINTE EAR, NOSE, THROAT & SINUS CENTERS TO SHARE ANY RELAVENT MEDICAL INFORMATION REGARDING THE ABOVE NAMED PATIENT INCLUDING BUT NOT LIMITED TO INFORMATION ABOUT APPOINTMENT TIME, DATE AND REASON FOR VISIT, BILLING INFORMATION, MEDICATIONS AND MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

FULL NAME _____ **DOB** _____ **RELATIONSHIP** _____

FULL NAME _____ **DOB** _____ **RELATIONSHIP** _____

FULL NAME _____ **DOB** _____ **RELATIONSHIP** _____

I understand that I may cancel this consent at any time in writing to CarePointe Ear, Nose, Throat and Sinus Center, but that cancelling it will not affect any information that has already been released.

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____
(If patient is a minor)

Patient Responsibility Policy

I authorize treatment of the person named above and agree to pay all fees associated with this treatment. I understand that my co-pay is due at the time of service. I authorize the assignment of insurance benefits and agree to pay the remaining balance as per my insurance contract.

I understand that I will be charged a $25 missed appointment /no-show fee if I do not give 24 hours advanced notice of cancellation. I understand that it is important to show up on time for my appointment.

I understand that it is my responsibility to make sure that CarePointe is in my network and that I have my referral and authorization for HMO insurance.

I understand that it is my responsibility to understand the policies of my insurance, such as co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date and termination date.

I understand that it is my responsibility to update the office of any changes in my insurance coverage or in my demographic information.

I understand that self-pay patients are required to pay at the time of service. I understand that I will be responsible for additional charges if the physician has to do other diagnostic services at the time of my appointment.

I authorize CarePointe to communicate appointment reminders and general message through all provided points of contact, which may include U.S. mail, e-mail and/or telephone numbers and voice mail.

For the safety of our patients and our staff, CarePointe has a zero-tolerance policy for any behavior that is deemed threatening, harassing or intimidating. CarePointe is committed to providing excellent patient care in a professional and respectful environment. _____ *patient's initials.*

DATE **SIGNATURE** **RELATION TO PATIENT**

CAREPOINTE HEALTH HISTORY

Date:_____

Dear valued Patient,

To comply with Government standards and improve our record keeping, it is important that you fill out this form as completely as possible so that we may gather information in a more meaningful way for your treatment and care.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐Male ☐Female **Height** _____ **Weight** _____ **DOB** _____ **Occupation**_____

Pharmacy Preference (include location/phone)_____

Name of Primary Care Physician _____

Name of Physician referring you today _____

Do you use tobacco products? ☐ **YES** ☐ **NO**

Approximate date (MO/YR) of last Influenza Vaccine_____ **Declined Vaccine** ☐ **Never Received Vaccine** ☐

Approximate date (MO/YR) of last Pneumonia Vaccine_____ **Declined Vaccine** ☐ **Never Received Vaccine** ☐

Approximate date (MO/YR) of last Colonoscopy_____ **Declined Colonoscopy** ☐ **Never Received Colonoscopy** ☐

Approximate date (MO/YR) of last Mammogram_____ **Declined Mammogram** ☐ **Never Received Mammogram** ☐

Approximate date (MO/YR) of last Pap Smear_____ **Declined Pap Smear** ☐ **Never Received Pap Smear** ☐

REASON FOR TODAY'S VISIT_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: Use back if more space is needed

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ **Yes** ☐ **No** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS Use back if more space is needed

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No

If yes, please list type of problems_____

List any surgeries you have had (including dates)_____

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ Yes ☐ No

If yes, list reasons for hospitalizations_____

_____