PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

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

Sex ☐ Male ☐ Female **Date of Birth:** _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

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:

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 _____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

*Please proceed to the next page.

DEARBORN EAR NOSE AND THROAT CLINIC

FREDERICK L LOPATIN, DO ARIEL A. WAITZMAN, MD

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Full Time Student: ☐ Yes ☐ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ☐ Physician ☐ Family ☐ Friend ☐ Phone Book ☐ Insurance Co. ☐ Other _____

Referring Physician's Name: _____ Phone No: _____

Address: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____

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HIPAA

NOTICE AND ACKNOWLEDGMENT

I acknowledge that I have been offered and/or received the attached Notice of Privacy Practices

_____ _____

Signature of Patient or Personal Representative Date

Record Release

As of November 15, 1999 in an effort to promote patient confidentiality and in an attempt to comply with HIPPA this office requires that all release of information requests includes a statement that is signed by the patient that we may divulge (if present in the chart): Chemical dependency / drug abuse, HIV status, Psychiatric / Psychological Information.

Please list any Physicians that you would like to have access to your records below:	Please list family members or others that you would like to have access to your records below:

_____ _____

Patient or Personal Representative Signature Date

_____

Witness signature (for office use only)

Notice

Due to the constant changes in insurance,
It is no longer possible to interpret each individual's policy.
Although we try to stay aware of these changes,

It is not possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Please do not get angry at us
If your insurance does not cover our services.
All insurance policies have exclusions and most policies have deductibles and co-payments.

Please remember that your insurance policy
IS between you and your insurance company,
And **NOT** between the insurance company and the doctor.

_____ / / _____

Signature of insured or responsible party date