LAKESIDE ALLERGY, EAR, NOSE & THROAT

Patient Information

Name (Last)_____(First, Middle Initial)_____DOB____/____/_____
Social Security # _____ Marital Status: S M D W Gender: M F
Mailing Address_____(City)_____(State)_____(Zip)_____
Phone (Home)_____(Cell)_____(Work)_____
Spouse/Parent Name_____Spouse/Parent phone _____
Email_____Pharmacy Name/Address_____
Race: American Indian; Black; Asian; White; Multiracial; Other
Ethnicity: Hispanic or Latino; Not Hispanic or Latino
Language: English; Spanish; Chinese; French; Arabic; Vietnamese; Other
Referred to the clinic by: Doctor; Insurance; Hospital; Family; Friend; Internet; Other

Parent/Responsible Party Information (if patient is under 18)

Name (Last)_____(First, Middle Initial)_____DOB____/____/_____
Social Security # _____ Relationship to Patient_____
Mailing Address_____(City)_____(State)_____(Zip)_____
Phone (Home)_____(Cell)_____(Work)_____

Is the Insured the same as the Responsible Party? Y or N If no, please fill out information below

Name (Last)_____(First, Middle Initial)_____DOB____/____/_____
Social Security # _____ Relationship to Patient_____
Mailing Address_____(City)_____(State)_____(Zip)_____
Phone (Home)_____(Cell)_____(Work)_____

Emergency Contact

Name (Last)_____(First, Middle Initial)_____Relationship
to Patient_____Phone
(Home)_____(Cell)_____(Work)_____

Primary Care Physician

Name (Last)_____(First)_____City _____

Referring Physician

Name (Last)_____(First)_____City _____

I authorize the physician(s) of Lakeside Allergy ENT to treat me. I authorize any physician/agent of Lakeside Allergy ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of Lakeside Allergy ENT. I authorize any physician/agent of Lakeside Allergy ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay the medical benefits directly to the physician(s) of Lakeside Allergy ENT. I understand that I am financially responsible for any balance. I agree that a photocopy of this agreement will be considered the same as the original.

Patient/Guardian Signature_____Date_____

LAKESIDE ALLERGY, EAR, NOSE, & THROAT

Gregory A. Young, M.D., P.A. Jeffrey West, M.D., FACS
Kenny Iloabachie, M.D. Andrew Chang, M.D.

AUTHORIZATION FOR DISCLOSURE FOR PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:

Lakeside Allergy, Ear, Nose, & Throat
1320 Summer Lee Drive
Rockwall, TX 75032

B. Person(s) or Organization(s) authorized to receive the information:

_____

C. Specific description of the information that may be used or disclosed (including date(s)).

_____

D. Specific description of how the information will be used:

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1) I understand that this authorization will **expire** on _____/_____/_____
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization at any time by notifying Lakeside Allergy, Ear, Nose & throat in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____

E. Authorization to leave messages:

I give permission for the staff of Lakeside to give or leave messages or information regarding medication, surgery, lab results, appointments and healthcare by the following:

- □ **Home telephone answering machine (____)_____-_____**
- □ **Cell Phone Voicemail (____)_____-_____**
- □ **My Email Address _____**
- □ **USPS Mailing Address _____**

Please indicate any additional names of individuals with whom we may speak with concerning your care:

_____

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.")
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).
You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD/Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

LAKESIDE ALLERGY, EAR, NOSE & THROAT

IN OFFICE PROCEDURE AND TESTING CONSENT FINANCIAL ACKNOWLEDGEMENT

Lakeside Allergy wants to inform you of certain additional charges that may apply to your visits if you are complaining of sinus, ear or throat problems. If you are here for a consultation, new patient visit, follow-up visit, or post-op visit, it may be necessary for the doctor to do certain procedures such as nasal endoscopy, laryngoscopy, microscopy, hearing tests, or allergy screens. Insurance companies sometimes apply these procedures/surgeries to your coinsurance and/or deductible as they are classified as "in office procedures/surgery".

You may owe more than your office visit co-payment at check out. If you have any questions about your specific insurance plan benefit and your financial responsibility, please ask one of the receptionists or check with your insurance carrier before seeing the doctor. Please indicate your understanding and consent of these procedures by signing below.

I acknowledge and understand that additional testing including procedures may be performed for my evaluation and treatment if the doctor finds it medically necessary. I also understand that I may owe more money than my office visit or copay should the procedure be applied to my deductible and/or coinsurance.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA). If you would like a copy of the Notice of Privacy Practices, please notify the front staff.

I hereby request the following restrictions on the use and/or disclosure of my information: _____

_____

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian Relationship

_____ _____

Witness Date

04/12/2018 PS

LAKESIDE ALLERGY, EAR, NOSE & THROAT

Please Initial:

_____Co-Pays, Coinsurance, and Deductibles are due at the time of service. We accept **Cash, VISA, MasterCard, Discover, and American Express.**

_____**REFERRALS:** If you have an HMO, or similar plan, you will need a referral from your primary care physician to see our specialists. If we have not received this referral prior to your arrival at our office, your appointment may need to be rescheduled. It is YOUR responsibility to know if a referral is required and to obtain one.

_____**INSURANCE BENEFITS:** It is the patient's responsibility to know their insurance benefits and to know the in-network and out-of-network status for our providers; this can be checked by calling the insurance company. Please be aware that when a patient requires a visit to a specialist, there are procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures/surgeries. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, an estimated cost of the procedure will be given before the procedure is performed, and must be paid in full at time of service. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Nasal Hemorrhage Control	Cerumen (ear wax) Removal
Foreign Body Removal	Tympanostomy/Myringotomy
Audio-Comprehensive	Otoacoustic Emissions
Binocular Microscopy	Flexible Laryngoscopy
Nasal Endoscopy with/without Debridement	

_____**FORM FEES:** Any forms (i.e. FMLA, Short-term disability, other extended leave of absences, etc.) which require our physicians to complete, must be given to our office staff in a timely manner and will require a $25.00 fee before being completed. Please allow 10 business days for completion.

_____**MEDICAL/BILLING RECORDS FEE:** Any request for medical or billing records must be accompanied by an authorization for release of information (obtainable from the front desk). We will make every effort to provide your records via copies or electronically, within 10 business days, so please make your request well in advance of other physician appointments. There is a $25.00 fee for medical records.

_____**RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason. Lakeside Allergy ENT does report all bad check to the Justice of the Peace.

_____**COLLECTION AGENCY:** Please be aware that Lakeside Allergy ENT reports unpaid bills to a collection agency. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account. Any patient sent to collection forfeits any future appointments unless the balance is paid in full.

_____**SURGERY PAYMENTS:** If surgery is recommended, you may be required to pay a portion of your deductible and/or coinsurance prior to the date of surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim.

_____**ASSIGNMENT OF BENEFITS:** I request that payment of insurance benefits, be made on my behalf to Lakeside Allergy, Ear, Nose, & Throat or Gregory A. Young, M.D. PA or Jeffrey A. West, M.D. FACS, Kenny Iloabachie, M.D., or Andrew J. Chang, M.D. for any services provided to me. I authorize the release of any medical or other information necessary to determine these benefits or benefits payable by my insurance carrier. A copy of this authorization will be sent to my insurance carrier if requested. The original authorization will be kept on file at Lakeside Allergy, Ear, Nose, & Throat.

_____**FINANCIAL RESPONSIBILITY:** I have read this notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these procedures will be billed to my insurance, if any. I understand there are other procedures which may be performed as part of my diagnosis or treatment that may not be listed above. I will be responsible for any amount not covered by my insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify Lakeside Allergy ENT of any changes in my insurance coverage. I understand by signing this form I am accepting full financial responsibility as explained above for all payment for services rendered.

_____**NO SHOW/CANCELLATION COURTESY:** Lakeside Allergy ENT requires 24 hour notice if you are unable to keep your scheduled appointment. If you "no show" for an appointment or cancel with less than 24 hours notice, you will be charged a $30.00 fee.

DISCLOSURE STATEMENT: Please be advised that the physicians may have a direct financial interest in a facility to which our practices refers. You have a right to choose the facility of your choice.

Signature: _____

Printed Name: _____

Relationship to patient, if different: _____

Witness: _____

Date: _____

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DATE:_____/_____/_____

NAME:_____ DATE OF BIRTH:_____/_____/_____AGE: _____

WEIGHT:_____HEIGHT:_____B/P:_____MALE OR FEMALE (circle one)

REASON FOR VISIT: _____

_____

When symptom first occurred: _____

Possible Cause: _____

Has this problem occurred in the past? ☐ Yes ☐ No

MEDICAL HISTORY

Please list all medical problems that you currently have and when they first occurred:

Medical Problem	Date First Occurred
Asthma	_____/_____/_____
Diabetes	_____/_____/_____
Heart Disease	_____/_____/_____
Cancer	_____/_____/_____
Stomach Ulcer	_____/_____/_____
Free Bleeding	_____/_____/_____
Easy Bruising	_____/_____/_____
☐ _____	_____/_____/_____
☐ _____	_____/_____/_____
☐ _____	_____/_____/_____

SURGICAL HISTORY

Please list any previous surgeries and when they were performed. Also list any problems with anesthesia.

1._____ Date:_____/_____/_____

2._____ Date:_____/_____/_____

3._____ Date:_____/_____/_____

4._____ Date:_____/_____/_____

Problems with anesthesia: _____

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NAME: _____ DATE OF BIRTH:_____/_____/_____AGE: _____

FAMILY HISTORY

Please **Check** all of the following conditions that run in your family:

- ☐ Allergies
- ☐ Anesthetic Problems
- ☐ Angioedema
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Lupus
- ☐ Meniere's Disease
- ☐ Multiple Sclerosis
- ☐ Retinitis Pigmentosa
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Other _____
- ☐ Other _____

SOCIAL HISTORY

Cigarettes: Yes ☐ No Packs/day:_____ Years:_____I quit_____years ago

Other Tobacco: Yes ☐ No Cigar ☐ Dip/Chew

Alcohol: Yes ☐ No Drinks/day:_____Years: _____

MEDICATION HISTORY

List the medications and supplements that you currently take. Include prescription medication, over the counter medications, supplements, and herbal medicines, dosage, and strength.

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____
7. _____ Dosage: _____
8. _____ Dosage: _____

DRUG ALLERGIES

List any drug allergies that you have experienced and the type of reaction that occurred. _____

_____

_____

FOOD AND ENVIRONMENTAL ALLERGIES

List any environmental or food allergies that you have experienced and the type of reaction that occurred. _____

_____

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Kenny Iloabachie, M.D. Andrew Chang, M.D.

DATE: _____ / _____ / _____ NAME: _____
DATE OF BIRTH: _____ / _____/ _____AGE: _____MALE OR FEMALE (circle ONE)

Please indicate what symptoms you are currently experiencing:

FEVER	☐ Yes ☐ No	DYSPHAGIA (PROBLEM SWALLOWING)	☐ Yes ☐ No
NIGHT SWEATS	☐ Yes ☐ No	HEPATITIS	☐ Yes ☐ No
WEIGHT LOSS	☐ Yes ☐ No	GERD (HEARTBURN)	☐ Yes ☐ No
BLINDNESS	☐ Yes ☐ No	PREGNANCY	☐ Yes ☐ No
VISION CHANGE	☐ Yes ☐ No	URINARY RETENTION (Problem Urinating)	☐ Yes ☐ No
ITCHING EYES	☐ Yes ☐ No	RASH	☐ Yes ☐ No
NASAL ALLERGY	☐ Yes ☐ No	MOLE CHANGE	☐ Yes ☐ No
NASAL OBSTRUCTION	☐ Yes ☐ No	SKIN CANCER	☐ Yes ☐ No
FACIAL PAIN	☐ Yes ☐ No	SYNCOPE (BLACKING OUT)	☐ Yes ☐ No
SINUSITIS	☐ Yes ☐ No	SEIZURE	☐ Yes ☐ No
SNORING	☐ Yes ☐ No	WEAKNESS	☐ Yes ☐ No
SLEEP DISORDER (Breathing)	☐ Yes ☐ No	SPEECH DIFFICULTY	☐ Yes ☐ No
LUMP IN THROAT	☐ Yes ☐ No	HEADACHES	☐ Yes ☐ No
VOICE CHANGE	☐ Yes ☐ No	PARESTHESIA (NUMBNESS)	☐ Yes ☐ No
HEARING LOSS	☐ Yes ☐ No	DRUG ABUSE	☐ Yes ☐ No
OTALGIA (EAR PAIN)	☐ Yes ☐ No	ALCOHOL ABUSE	☐ Yes ☐ No
TINNITUS (RINGING IN THE EARS	☐ Yes ☐ No	ANXIETY	☐ Yes ☐ No
NECK MASS	☐ Yes ☐ No	DEPRESSION	☐ Yes ☐ No
VERTIGO (DIZZINESS)	☐ Yes ☐ No	DIABETES (INSULIN)	☐ Yes ☐ No
SORE THROAT	☐ Yes ☐ No	DIABETES II (ORAL MEDICATION)	☐ Yes ☐ No
CHEST PAIN/PRESSURE	☐ Yes ☐ No	GOITER	☐ Yes ☐ No
EXERCISE INTOLERANCE	☐ Yes ☐ No	THYROID NODULE	☐ Yes ☐ No
ASTHMA	☐ Yes ☐ No	HYPERTHYROIDISM (THYROID TOO HIGH)	☐ Yes ☐ No
COUGH	☐ Yes ☐ No	HYPOTHYROIDISM (THYROID TOO LOW)	☐ Yes ☐ No
HEMOPTYSIS (COUGHING BLOOD)	☐ Yes ☐ No	HYPERCALCEMIA (CALCIUM TOO HIGH)	☐ Yes ☐ No
DYSPNEA(SHORTNESS OF BREATH)	☐ Yes ☐ No	ABNORMAL BLEEDING OR BRUISING	☐ Yes ☐ No
TUBERCULOSIS	☐ Yes ☐ No	LYMPH NODE ENLARGED	☐ Yes ☐ No
NAUSEA	☐ Yes ☐ No	SKIN RASH (URTICARIA)	☐ Yes ☐ No
VOMITING	☐ Yes ☐ No	FOOD ALLERGIES	☐ Yes ☐ No

Other Symptoms not listed: _____