BLACK CREEK
MEDICAL CONSULTANTS
EAR, NOSE & THROAT DIVISION

NEW PATIENT INFORMATION

Please read carefully, print, and complete in full.

NAME (FIRST, MIDDLE LAST)	MARITAL STATUS (S / M / W / D / SEP)	DATE OF BIRTH	AGE	SEX (M / F)	SOCIAL SECURITY NUMBER

ADDRESS (INCLUDE APARTMENT NUMBER)	CITY & STATE	ZIP	HOME PHONE (INCLUDE AREA CODE)

CELL PHONE (INCLUDE AREA CODE)	EMAIL ADDRESS

RACE	ETHNICITY
▢ American Indian or Alaska Native ▢Asian ▢Black or African American ▢Native Hawaiian or Other Pacific Islander ▢ White	▢Hispanic or Latino ▢Not Hispanic or Latino

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMP?	BUSINESS PHONE

EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP)

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

EMPLOYER OF ABOVE NAME	OCCUPATION	EMPLOYER PHONE

NAME OF NEAREST RELATIVE	RELATION	RELATIVE'S PHONE

EMERGENCY CONTACT OUTSIDE OF HOME	RELATION	EMERGENCY PHONE

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN SEEN BY OUR PHYSICIAN BEFORE? ▢ YES ▢ NO If YES,NAME OF PHYSICIAN _____DATE SEEN?_____

REFERRED BY	ADDRESS, CITY STATE, ZIP	PHONE

FAMILY DOCTOR (IF DIFFERENT THAN ABOVE)	ADDRESS, CITY, STATE, ZIP	PHONE

HAVE YOU HAD X-RAYS, CT SCAN, MRI SCAN, ETC. FOR PROBLEM OR INJURY BEING SEEN FOR TODAY? ▢ YES ▢ NO	IF YES, WHEN & WHERE?

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	DOES YOUR INSURANCE REQUIRE PRIOR AUTHORIZATION FOR TREATMENT? ▢ YES ▢ NO

NAME OF POLICY HOLDER	POLICY HOLDER'S DATE OF BIRTH	PHONE NUMBER TO CALL FOR AUTHORIZATION

GROUP NUMBER	POLICY NUMBER

ADDRESS OF INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

NAME OF POLICY HOLDER	DATE OF BIRTH

GROUP NUMBER	I.D. NO/CERTIFICATE NO

ADDRESS OF INSURANCE COMPANY

WORKERS' COMPENSATION

WERE YOU INJURED ON THE JOB? ▢ YES ▢ NO	DATE OF ACCIDENT

WORKMENS' COMPENSATION CENTER	CLAIM NO

ADDRESS	ATTENTION TO:

CITY, STATE, ZIP

PHONE NUMBER	VERIFIED BY

EMPLOYER AT TIME OF ACCIDENT

GUARANTOR INFORMATION

GUARANTOR/LEGAL GUARDIAN'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS	CITY, STATE, ZIP

HOME PHONE	CELL PHONE

RELATION	EMAIL ADDRESS

BLACK CREEK
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FINANCIAL DUE DILIGENCE and CONSENT FOR TREATMENT

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that payment of authorized benefits – Medicare, Medicaid, and/or any insurance carrier, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to Black Creek Medical Consultants, LLC, the Health Care Financing Administration, listed insurer, and/or agents of the company and or the listed responsible person(s), any information needed to determine these benefits or the benefits for the related services.

- I acknowledge that I have received information regarding my rights to privacy of information under HIPAA regulations
- I further acknowledge that if I want my protected health information disclosed, I must make that request to the staff and sign a disclosure release.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTEE OF PAYMENT

In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the physician(s). I understand that any balance due as a result of being uninsured or underinsured is payable immediately. I further understand that if I fail to maintain any payment, my account may be sent to their collection agent and/or attorney.

PRECERTIFICATION

I understand that if my insurance has a precertification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

PATIENT SIGNATURE: _____ **RELATIONSHIP:** _____

WITNESS: _____ **DATE:** _____

CONSENT FOR TREATMENT

I do voluntarily consent to the rendering of such care as the physician(s) and personnel of Black Creek Medical Consultants, LLC, in their judgement, deem necessary for my health and wellbeing.

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (including suturing) and the carrying out of the orders of my treating physician by office personnel. I acknowledge that neither the physician nor the office personnel have made any guarantee or assurance as to the results that may be obtained.

I HAVE READ AND UNDERSTAND THIS CONSENT:

PATIENT SIGNATURE: _____ **RELATIONSHIP:** _____
(to be signed by parent or legal guardian if patient is a minor under the age of 18 or is a mentally incompetent patient)

WITNESS: _____ **DATE:** _____ **TIME** _____ ☐**AM** ☐**PM**

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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I have reviewed and received a copy (if I requested one) of this office's HIPAA Notice of Privacy Practices explaining this office's obligations concerning the use and disclosure of my protected health information, how they will use and disclose my protected health information, and my privacy rights with regard to my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of the revised version upon request. I also understand that if I have any questions or complaints, I may contact the Privacy Officer of the practice at:

BLACK CREEK MEDICAL CONSULTANTS, LLC
606 Medical Park Drive
Hartsville, SC 29550-4782
Phone 843/383-5312

The Secretary of the U.S. Department of Health and Human Services may also be contacted with any concerns regarding Black Creek Medical Consultant's privacy and security policies and procedures at: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Washington, DC 20201.

By signing below, I also provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment, and healthcare operations as outlined in the Notice of Privacy Practices.

SIGNATURE OF PATIENT (or personal representative) _____**DATE** _____

PRINTED NAME OF PATIENT (or personal representative) _____

RELATIONSHIP TO PATIENT _____

For office use only:

We made a good faith attempt to obtain a HIPAA Acknowledgement from our patient _____ but were unable to do so due to:

- ▢ patient refusing to sign on this date
- ▢ communication barriers
- ▢ an emergency situation preventing us from being able to obtain a signed acknowledgement
- ▢ other _____

I attest that the above information is correct.

SIGNATURE OF PRACTICE REPRESENTATIVE _____DATE _____

PRINTED NAME OF PRACTICE REP_____TITLE _____

BLACK CREEK
MEDICAL CONSULTANTS
EAR, NOSE & THROAT DIVISION

CONSENT TO CALL &

E-PRESCRIBING & MEDICATION HISTORY DOWNLOAD CONSENT

PATIENT NAME: _____**Date of Birth** _____/_____/_____ **Date** _____

Please list any person that health information may be released to on your behalf in any form such as: phone, fax, in person, in writing, etc. Please list all family members or friends and their relation to you.

NAME	RELATIONSHIP	PHONE

Please check **YES** or **NO** to the following question: ** Please note that test results will not be left on any answering machine.*

▢ YES ▢ NO It is okay to leave a detailed message by phone, text, or email on the following phone numbers or email addresses regarding any appointment or account balance? If YES, please provide:

Phone Numbers _____ _____

Email Addresses _____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____**DATE** _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-prescribing program. These include:

- ***Formulary and benefit transactions*** – gives the prescriber information about which drugs are covered by the drug benefit plan.
- ***Medication history transactions*** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- ***Fill status notification*** – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Black Creek Medical Consultants, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Black Creek Medical Consultants, LLC to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT NAME (printed) _____**DATE OF BIRTH** _____/_____/_____ **DATE**_____

SIGNATURE OF PATIENT OR GUARDIAN _____**RELATIONSHIP TO PATIENT** _____

BLACK CREEK
MEDICAL CONSULTANTS
EAR, NOSE & THROAT DIVISION

ENT, ALLERGY & SLEEP MEDICINE MEDICAL HISTORY AND PROBLEMS

PATIENT NAME _____ **AGE** _____ **DATE COMPLETED** _____

Family or Referring Physician _____ Preferred Pharmacy _____

What is the reason or problem(s) for which you are being seen today? _____

_____

List any doctors, tests, treatments, or hospitalizations you have had for the reason/problem(s) shared above_____

_____

Have you had any of these done for the above reason/problem(s): *(check all that apply)* ▢x-rays ▢MRI ▢CT Scan ▢Nerve Conduction Study

If so, where were these tests performed? _____

Vitals: BP _____ Pulse _____ Resp _____ Temp_____ Weight _____ Height _____

PAST MEDICAL HISTORY

List all medications, the dose you take, and how often you take it (include over the counter medicines, vitamins, herbal supplements, etc.)

Name of Medication	Dose	Frequency (how often taken)

Please check any medications that you are either allergic to or that you cannot take:

	Anesthetics		Aspirin		Barbituates
	Codeine		Demerol		Penicillin
	Morphine		Sulfa		Other _____

List any surgeries you have had and the year the surgery took place:

Type Surgery	Year Done	Type Surgery	Year Done

Any other medical problems, please list: _____

_____

Do you have a pacemaker? ▢ YES ▢ NO

Are you taking any blood thinners? ▢ YES ▢ NO

What about Plavix, Coumadin or Aspirin? ▢ YES ▢ NO If YES, how often? _____

Scribed by: _____Reviewed by Physician _____

CIRCLE any of the medical problems that you or your family may have:

AIDS/HIV	Self	Mother	Father	Brother	Sister
Arthritis	Self	Mother	Father	Brother	Sister
Blood Disorder	Self	Mother	Father	Brother	Sister
Cancer/Type/Area	Self	Mother	Father	Brother	Sister
Diabetes	Self	Mother	Father	Brother	Sister
High Cholesterol	Self	Mother	Father	Brother	Sister
High Blood Pressure	Self	Mother	Father	Brother	Sister
Heart Disease	Self	Mother	Father	Brother	Sister
Kidney Disease	Self	Mother	Father	Brother	Sister
Lung Disease	Self	Mother	Father	Brother	Sister
Neurological (seizures, etc.)	Self	Mother	Father	Brother	Sister
Stomach (ulcer, reflux, etc.)	Self	Mother	Father	Brother	Sister
Stroke	Self	Mother	Father	Brother	Sister

REVIEW OF SYSTEMS

CIRCLE any of the following symptoms you have had in the past few months:

Cough	Morning hoarseness	Dizziness	Ringing in the ears
Snoring	Daytime fatigue	Sleepiness	Thyroid problems
Rashes	Night sweats	Sinus/Allergies	Face/Neck Lumps/Growth
Sour taste	Post nasal drainage	Hearing loss	Lump in throat swallowing
Itchy eyes	Chest pain	Trouble breathing through nose	

SOCIAL HISTORY

Marital Status: ▢Married ▢Widowed ▢Divorced ▢Separated

Employment: ▢Working ▢Retired ▢Disabled ▢Unemployed

If working, what position, title or job description: _____

_____

Are you a student? ▢ YES ▢ NO If YES, what school? _____What grade? _____

List any hobbies, activities, or sports you participate in: _____

Tobacco Use? ▢ YES ▢ NO (includes cigarettes, cigars, pipes, snuff) If YES, how much? _____how long? _____

Recreational Drugs? ▢ YES ▢ NO (marijuana, cocaine, heroin, crack) If YES, how much? _____how long? _____

The statements above are true to the best of my knowledge.

PATIENT'S SIGNATURE _____**DATE** _____

REVIEWED BY PHYSICIAN _____

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REVIEW OF SYSTEMS

PATIENT NAME: _____ **DATE** _____

Please ***CIRCLE*** all symptoms that pertain to the patient:

If you are having trouble with your ear(s), please ***circle*** RIGHT, LEFT, or BOTH.

If you are having trouble with your nose, please ***circle*** RIGHT or LEFT.

Allergies/Sinus	Trouble Swallowing	**SLEEP PATTERN QUESTIONNAIRE**:
Itchy Eyes	Sore Throat	Choking
Watery Eyes	Lump in Throat	Irregular Breathing Pattern
Hearing Loss (RIGHT, LEFT, BOTH)	Hoarseness	Extreme Sleepiness
Hearing Noises in Ear (RIGHT, LEFT, BOTH)	Mucus in Throat	Irritability
Ringing in Ears (RIGHT, LEFT, BOTH)	Coughing	Moodiness
Pain in Ear(s) (RIGHT, LEFT, BOTH)	Tickle in Throat	Morning Headaches
Drainage from Ear (RIGHT, LEFT, BOTH)	Coughing when Lying Down	Facial Abnormalities
Runny Nose	Coughing when Hot or Cold	Snoring
Sneezing	Coughing after Eating	Feeling Tired
Bleeding from Nose (RIGHT, LEFT)	Mucus in Chest	Trouble Breathing at Night
Stopped up Nose (RIGHT, LEFT)	Feeling Hot or Cold	Trouble Staying Asleep
Itchy Nose	Lump in Neck	Trouble Sleeping
Pain in Nose (RIGHT, LEFT)	Feeling Tired	Gasping for Breath
Problems Breathing thru Nose (RIGHT, LEFT)	Headaches	
Spinning Room		
Dizziness when turning Head Left or Right		
Dizziness when Lying Down		
Dizziness when Bending Over		
Dizziness when Sitting Up		

Reviewed by Physician _____