PEACHTREE E.N.T. & FACIAL PLASTICS
PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY

TODAY'S DATE _____

PATIENT NAME: _____ DOB: _____ RACE: _____ SEX: M F

LOCAL MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE#: _____ SOCIAL SECURITY#: _____

EMAIL ADDRESS: _____

EMPLOYER NAME: _____ WORK PHONE#: _____

CELL PHONE#: _____ MARITAL STATUS: S M W D

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

PART TIME RESIDENTS PLEASE PROVIDE YOUR ALTERNATE MAILING ADDRESS:

ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP CODE: _____

IF PATIENT HAS A LEGAL GUARDIAN OR IS A MINOR PLEASE PROVIDE THE FOLLOWING

GUARDIAN OR PARENT NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE #: _____ CELLPHONE #: _____

REFERRED FROM: ☐ YELLOWPAGES ☐ FRIEND ☐ INSURANCE ☐ DOCTOR ☐ NEWSPAPER/PUBLICATION ☐ BILLBOARD
REFERING DOCTOR NAME: _____ **PHONE#:** _____

EMERGENCY CONTACT: NEAREST RELATIVE, NEIGHBOR, OR FRIEND NOT LIVING WITH YOU (IN CASE YOU CAN'T BE REACHED)

NAME: _____ PHONE#: _____

PRIMARY INSURANCE: _____ **ID#** _____

SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

SECONDARY INSURANCE: _____ **ID#** _____

SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

TREATMENT AUTHORIZATION

I hereby give PeachTree ENT & Facial Plastics consent for medical treatment.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Today's Date: _____

Peachtree E.N.T & Facial Plastics

Patient History

Today's Date: _____

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

Family Doctor: _____ Dr.'s Phone : _____

Pharmacy: _____ Pharmacy #: _____

What are you here for today? _____

_____

Current Medications: Include **ALL** prescriptions, over the counter meds, vitamins, minerals & herbals:
Specifically: Coumadin, Plavix, Aspirin, etc. Any blood thinning medications.

Drug Name	Dose(mg)	How often	Drug Name	Dose (mg)	How often

Medical History: *list all medical problems you are being treated for:* _____

_____

_____

Allergies/Intolerance: **Reactions:**

_____ _____

_____ _____

_____ _____

Please check if allergic to the following: ___Latex ___Adhesive tape ___Novocain ___Lidocaine ___Epinephrine

Surgeries – Check if you have had any of the following surgeries

__ Tonsils/Adenoids __Ear/Mastoid __Nasal sinus/Septum/Polyps __Head/neck cancer or surgery __Salivary glands

List all other surgeries/complications here: _____

_____

Hospitlizations: Check if only for surgery_____

Otherwise list hospitalizations here: _____

_____

Family History: circle one of the following:

Father: alive/deceased

Mother: alive/deceased

Siblings: alive/deceased _____# of boys _____# of girls

Natural children: alive/deceased _____# of boys _____ #of girls

NAME _____ DATE _____

Social History:

Do you smoke cigarettes Yes /No ____ packs per day _____ # of years

Do you smoke cigars or a pipe Yes /No _____ # per day _____# of years

Do you chew or dip tobacco Yes/ No _____ #of years; Quit? How long_____

Did you ever smoke Yes / No _____ #of years ago; Packs per day_____

Do you drink alcoholic beverages Yes / No How much_____

Do you use or ever used illegal substances Yes /No

Do you drink caffeine products Yes/ No What & how much_____

Have you ever had difficulty with Anesthesia? Yes No
If so please explain_____
Have you ever been diagnosed with a Bleeding Disorder? Yes No
If so please explain_____
Are you presently under the care of a Cardiologist? Yes No
If so please explain_____
Name and number_____
Do you have to take antibiotics prior to invasive procedures? (because of pacemaker, mitral valve prolapse, joint replacements etc....) Yes No
If so please explain_____

Are you on any blood thinners, including aspirin? Yes No
If there is anything else that the doctor should know please write it here:
_____
_____
_____
_____

Rx HISTORY CONSENT

Permission is granted by the above named patient I POA I or legal guardian to view the patient's prescription history from external sources. This consent allows Dr. Weisenburger to send prescriptions to your pharmacy electronically

____INITIAL

PHYSICIAN ABSENTEE GUIDELINES

Dr. Weisenburger is the only E.N.T surgeon in Cherokee County. Because of this, he cannot be available at all times. Therefore, in case of an emergency you will need to seek medical attention at the nearest emergency room and be treated appropriately. Your signature below indicates you understand and agree to follow the necessary obligation.

____ INITIAL

PLEASE MARK EACH LINE WITH ONE ANSWER NAME_____ DATE _____

HAVE YOU HAD:

CONSTITUTIONAL

Weight gain	0 Yes	0 No
Fever	0 Yes	0 No
Weakness	0 Yes	0 No
Weight loss	0 Yes	0 No
Night sweats	0 Yes	0 No
Restless sleep	0 Yes	0 No
Always tired	0 Yes	0 No
Antibiotics required for Dental care	0 Yes	0 No
Exercise Tolerance	0 Yes	0 No

EYES

Dry eyes	0 Yes	0 No
Itchy eyes	0 Yes	0 No
Watery eyes	0 Yes	0 No
Pressure in eyes	0 Yes	0 No
Blurred vision	0 Yes	0 No
Loss of vision	0 Yes	0 No
Eye pain	0 Yes	0 No
Glaucoma	0 Yes	0 No
Cataracts	0 Yes	0 No

EARS

Ear pain	0 Yes	0 No
Discharge from ears	0 Yes	0 No
Itchy ears	0 Yes	0 No
Wax	0 Yes	0 No
Feeling of fullness	0 Yes	0 No
Any hearing loss	0 Yes	0 No
Ringing in ears	0 Yes	0 No
Dizziness	0 Yes	0 No

NOSE

Obstruction	0 Yes	0 No
Dripping	0 Yes	0 No
Changes in smell	0 Yes	0 No
Bleeding	0 Yes	0 No
Sneezing	0 Yes	0 No
Sinus pressure	0 Yes	0 No
Head Cold	0 Yes	0 No

THROAT

Clearing	0 Yes	0 No
Hoarseness	0 Yes	0 No
Sore throat or pain in throat	0 Yes	0 No
Dry mouth	0 Yes	0 No
Do you snore	0 Yes	0 No
Choking	0 Yes	0 No

NAME_____ DATE _____

RESPIRATORY

Any shortness of breath	0 Yes 0 No
Chest congestion	0 Yes 0 No
Cough	0 Yes 0 No
Excess mucous	0 Yes 0 No
Wheezing	0 Yes 0 No
Stop breathing when asleep	0 Yes 0 No
Gasp for breath when awake	0 Yes 0 No
Fall asleep while driving	0 Yes 0 No
Hold your breath while sleeping	0 Yes 0 No
Asthma	0 Yes 0 No
Tuberculosis	0 Yes 0 No
Bronchitis	0 Yes 0 No
Pneumonia	0 Yes 0 No

ALLERGY/IMMUNOLOGIC

Swollen lips/tongue	0 Yes 0 No
Skin rash	0 Yes 0 No
Itching	0 Yes 0 No
Throat tightness	0 Yes 0 No
Hepatitis	0 Yes 0 No
Allergy to Dye	0 Yes 0 No
Allergy to Food/Medicines	0 Yes 0 No
AIDS	0 Yes 0 No
HIV+	0 Yes 0 No

DERMATOLOGY

Rash	0 Yes 0 No
Itchy skin	0 Yes 0 No
Hives	0 Yes 0 No
Bleeding	0 Yes 0 No
Non-healing sores or lesion	0 Yes 0 No

ENDOCRINOLOGY

Sleep disturbance	0 Yes 0 No
Cold intolerance	0 Yes 0 No
Heat intolerance	0 Yes 0 No
Night sweats	0 Yes 0 No
Thyroid disease	0 Yes 0 No
Diabetes - Insulin Dependent	0 Yes 0 No
Diabetes - Non-Insulin Dependent	0 Yes 0 No
Changes in Appetite	0 Yes 0 No
Changes in Weight	0 Yes 0 No

NEUROLOGY

Headaches	0 Yes 0 No
Seizures	0 Yes 0 No
Dizziness	0 Yes 0 No
Facial weakness	0 Yes 0 No
Fainting spells	0 Yes 0 No
Frequent morning headaches	0 Yes 0 No
Facial Weakness-Paralysis	0 Yes 0 No
Facial numbness	0 Yes 0 No
Facial Pain	0 Yes 0 No
Tremors	0 Yes 0 No
Memory Loss	0 Yes 0 No

NAME_____ DATE _____

GASTROENTEROLOGY

Nausea	0 Yes	0 No
Heartburn	0 Yes	0 No
Indigestion	0 Yes	0 No
Trouble swallowing	0 Yes	0 No
Acid reflux	0 Yes	0 No
Vomiting	0 Yes	0 No
Change in bowel habits	0 Yes	0 No
Diarrhea/Constipation	0 Yes	0 No

CARDIOLOGY

Chest pain	0 Yes	0 No
Palpitations	0 Yes	0 No
Heart murmur	0 Yes	0 No
Pain in jaw or neck	0 Yes	0 No
High blood pressure	0 Yes	0 No
Abnormal heart rhythm	0 Yes	0 No
Congestive heart failure	0 Yes	0 No
Mitral Valve Replacement	0 Yes	0 No
Pacemaker Patient	0 Yes	0 No
Leg Pain when walking	0 Yes	0 No
Tachycardia	0 Yes	0 No
Fainting	0 Yes	0 No
Vertigo	0 Yes	0 No
Edema	0 Yes	0 No

PSYCHIATRIC

Depression	0 Yes	0 No
Thoughts of suicide	0 Yes	0 No
Feeling anxious	0 Yes	0 No
Irritability	0 Yes	0 No
Mood Swings	0 Yes	0 No
Nightmares	0 Yes	0 No

MUSCULOSKELETAL

Neck pain	0 Yes	0 No
Jaw pain	0 Yes	0 No
Jaw clenching	0 Yes	0 No
Pain in jaw joints	0 Yes	0 No
Joint Replacement	0 Yes	0 No
Arthritis	0 Yes	0 No
Gout	0 Yes	0 No
Swelling	0 Yes	0 No
Redness	0 Yes	0 No

PEACHTREE E.N.T. & FACIAL PLASTICS, P.A.

FINANCIAL POLICY

PLEASE READ CAREFULLY

As your physician PeachTree Ent & Facial Plastics, PA is committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENTS FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, Mastercard, Visa, and Discover. Returned checks are subject to a service charge of $25.00 or 5% whichever amount is greater, And you will lose privilege to write checks in our office.

NO SHOWS— Patients who do not cancel appointments may be charged a $25.00 no show fee and may also be discharged from the practice after the second no show.

MEDICARE— Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare Provider we will file your Medicare claim for you. If you have a secondary insurance, please check with the front desk to see if we are participating with your insurance company.

MEDICARE REPLACEMENTS - We will file your claim with Medicare Replacements. You are responsible for any co-pay and deductible at time of service.

BLUECROSS/BLUESHIELD PPO & PPC COVERAGE - CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with this insurance company, we will file your insurance.

MEDICAID - There is a $3.00 co-pay for each visit.

WORKERS' COMPENSATION - It is your responsibility to call your employer to get the visit authorized, we will file your company's insurance. In the event you fail to prosecute this claim for Workers' Compensation for this illness or the condition is determined not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. **Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e. yearly physicals, x-rays, labs, hearing tests).**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not the insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY ON THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

FINANCIAL AGREEMENT ADDENDUM - Statement for any balances due will be mailed three (3) times. If no response is received from the patient or guarantor, the account will be sent to collections. Should it be necessary to forward an account to collections, all charges incurred during the collection process (postage fees, collection fees, etc.) will be the responsibility of the patient or guarantor. The signature below confirms you have read and understand this policy.

_____ _____

Signature of patient / POA / legal guardian Date

_____ _____

Signature of Witness Date

PeachTree E.N.T. & Facial Plastics, P.A.

Notice of Privacy Practices Acknowledgement

I understand that, under the health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of PeachTree E.N.T. & Facial Plastics, P.A.'s privacy practices available in the waiting room containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, unless you are bound to abide by such restrictions.
I may also give permission to any person(s) allowing them access to my personal health information.

PLEASE LIST NAMES: (Spouse, Children, etc.)

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and received a copy of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____
(Patient or Legal Guardian)

Relationship to Patient: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____