**ADAMS HANOVER ENT, LLC**

**JAMES A. MANNING, JR., M.D.**
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**JULEE A. EISENHART, C.R.N.P.**

□ **508 S. WASHINGTON STREET**
**GETTYSBURG, PA 17325**
**717-334-8171**

□ **HILLSIDE MEDICAL CENTER**
**250 FAME AVENUE, SUITE 201**
**ENTRANCE A**
**HANOVER, PA 17331**
**717-633-9229**

**PATIENT**: _____
**PHYSICIAN**:._____
**APPT DAY**: _____ **APPT DATE**: _____
**APPT TIME:** _____

**PLEASE ARRIVE 15 MINUTES EARLY. IF YOU ARRIVE WITHOUT COMPLETED NEW PATIENT PAPERWORK WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.**

IN AN EFFORT TO EXPEDITE THE REGISTRATION PROCESS AT OUR OFFICE AND COMPLY WITH INSURANCE DOCUMENTATION REQUIREMENTS, WE ARE SENDING YOU REGISTRATION AND MEDICAL HISTORY FORMS TO BE **COMPLETED IN INK.**

**BRING PHOTO ID FOR THE PARENT OR GUARDIAN OF MINOR CHILD, AND INSURANCE CARD FOR PATIENT.** IF YOUR INSURANCE REQUIRES A REFERRAL IT IS YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL AND BRING IT WITH YOU TO YOUR APPOINTMENT. IF YOUR PRIMARY CARE PHYSICIAN STATES THAT THEY WILL SEND IT TO OUR OFFICE PLEASE CALL OUR OFFICE PRIOR TO YOUR APPOINTMENT TO INSURE IT HAS ARRIVED.

IF YOU COME TO YOUR APPOINTMENT WITHOUT COMPLETING THE REFERRAL PROCESS YOU WILL BE ASKED TO SIGN A WAIVER ACCEPTING RESPONSIBILITY FOR PAYMENT, PAYABLE AT THE TIME OF THE VISIT, OR WE CAN RESCHEDULE YOUR APPOINTMENT. WE WILL NOT CALL YOUR PCP TO OBTAIN THE REFERRAL.

PLEASE CHECK WITH YOUR INSURANCE IF YOU HAVE ANY CONCERN THAT ADAMS HANOVER ENT IS A PARTICIPATING PROVIDER.

ALL COPAYS ARE DUE AT THE TIME OF THE VISIT. SELF PAY PATIENTS MUST PAY AT THE TIME OF THE VISIT.

**CHILDREN UNDER 18 YEARS OF AGE MUST BE ACCOMPANIED BY A PARENT/LEGAL GUARDIAN OR THE APPOINTMENT WILL BE RESCHEDULED. LEGAL GUARDIANS MUST HAVE PROOF OF GUARDIANSHIP VIA COURT-ISSUED DOCUMENTS BEARING NAME OF LEGALLY RESPONSIBLE PARTY AND NAME OF MINOR CHILD.**

THERE WILL BE A $30 CHARGE FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT RESCHEDULED AT LEAST 24 HOURS IN ADVANCE.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT OR IF THERE IS ANYTHING WE CAN DO TO ASSIST WITH YOUR APPOINTMENT PLEASE CALL OUR OFFICE. THANK YOU.

NAME:_____ DATE: _____
DESCRIBE THE MEDICAL PROBLEM YOU ARE HERE FOR:_____
_____

SYMPTOM START DATE:_____NOW: BETTER____ WORSE____SAME____
SEVERITY:____MILD____MODERATE____SEVERE WHAT THERAPIES HAVE YOU TRIED:_____
_____
WHAT TESTS HAVE YOU HAD:___CT___MRI___XRAY____BLOOD TESTS____ALLERGY TESTS
OTHERS:_____

PAST MEDICAL HISTORY: (CIRCLE)

SURGERIES: EAR - TUBES - T&A - EYES - APPENDIX - THYROID - HEART - BREAST - GALLBLADDER - HERNIA - PROSTATE - HYSTERECTOMY OTHER:_____

MEDICAL PROBLEMS: HYPERTENSION - HEART DISEASE - ASTHMA -DIABETES - HEPATITIS-HIV- REFLUX - BLEEDING DISORDER - CANCER (TYPE:_____)OTHER:_____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER MEDICATIONS) :

MEDICATION/DOSAGE REASON TAKEN

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

7._____ _____

8._____ _____

9._____ _____

DRUG ALLERGIES:(CIRCLE) NONE KNOWN - PENICILLIN - SULFA - ERYTHROMYCIN - ASPIRIN
OTHER:_____
SEASONAL ALLERGIES: (CIRCLE) GRASS - WEEDS - TREES - DOGS - CATS - DUST - MOLDS
LATEX ALLERGY:_____YES ____NO

SOCIAL HISTORY:
SMOKE____NO ____YES____PREVIOUS HOW MUCH?_____
____CIGARETTES ____PIPE
SMOKELESS TOBACCO ___NO____YES ___PREVIOUS HOW MUCH?_____
ALCOHOL ____NO ____YES ____PREVIOUS HOW MUCH?_____
____BEER ___WINE ____LIQUOR
ILLEGAL DRUGS ___NO ___YES ___PREVIOUS TYPE? _____
ASPIRIN ___NO ___YES AMOUNT?_____
BLOOD TRANSFUSION ____NO ____YES HIV POSITIVE ____NO ____YES
ARE YOU PREGNANT ___NO ___YES HEPATITIS ____NO____YES - ____A____B____C

**PATIENT NAME: _____ DATE**: _____

**FAMILY HISTORY:**

**HISTORY OF FAMILY ILLNESS:** __DIABETES __CANCER __HYPERTENSION __HEART __ KIDNEY __STROKE __BLEEDING DISORDER __HEARING LOSS

FATHER: __ALIVE (AGE:___) __DECEASED: CAUSE:_____
MOTHER: __ALIVE (AGE:___) __DECEASED: CAUSE: _____

**REVIEW OF SYSTEMS:**

**(CIRCLE YOUR CURRENT SYMPTOMS):**

**GENERAL:** ANOREXIA ANXIETY CHILLS FATIGUE FEVER SWEATS WEAKNESS INSOMNIA SLEEP DISORDER WEIGHT LOSS WEIGHT GAIN

**EYES:** BLURRED VISION REDNESS ITCH PAIN BLINDNESS DRY MACULAR DEGENERATION SWELLING OF EYE LIDS

**EARS:** R L HEARING LOSS R L DRAINAGE R L ITCH R L RINGING R L PAIN R L HEARING AIDS R L PRESSURE

**NOSE/SINUS:** SINUSITIS BLEEDING OBSTRUCTED BROKEN DISCHARGE DECREASED SMELL SNORING CONGESTION

**MOUTH:** LOSS OF TASTE PAIN DRY SORES/ULCERS BLEEDING DENTURES MOUTH BREATHING TMJ

**THROAT:** SORE HOARSENESS SWALLOWING PROBLEM TONSILLITIS PAIN FREQUENT CLEARING

**HEART:** PAIN MURMUR PALPITATIONS ANGINA PACEMAKER BLOOD CLOTS IRREGULAR HEART BEAT HEART ATTACK

**LUNGS:** COUGH SHORT OF BREATH COUGH PRODUCTIVE OF BLOOD PAIN WHEEZING SUPPLEMENTAL OXYGEN

**GASTROINTESTINAL:** HEARTBURN PAIN NAUSEA VOMITING DIARRHEA CONSTIPATION ACID REFLUX INDIGESTION

**GENITOURINARY:** KIDNEY DISEASE KIDNEY STONE URINARY FREQUENCY URINARY URGENCY PROSTATE ENLARGEMENT

**MUSCULOSKELETAL:** ARTHRITIS FIBROMYALGIA FRACTURES NECK PAIN NECK STIFFNESS NECK LUMP/MASS

**SKIN:** LESIONS RASHES ITCH ROSACEA ECZEMA PSORIASIS CHANGE IN MOLE HEAD/NECK

**NEURO:** STROKE WEAKNESS FACIAL WEAKNESS MULTIPLE SCLEROSIS SEIZURE NUMBNESS PARALYSIS TREMOR FREQUENT HEADACHES DIZZINESS LIGHTHEADEDNESS MIGRAINES HEAD INJURY

**PSYCHIATRIC:** ALCOHOL ABUSE DRUG ABUSE SUICIDE ATTEMPTS DEPRESSION ADHD
**ENDOCRINE:** DIABETES GOITER THYROID DISEASE NIGHT SWEATS
**BLOOD:** ANEMIA LEUKEMIA HEPATITIS HIV FREE BLEEDER

**ADAMS HANOVER ENT**
Diseases of the Ear, Nose and Throat
Head and Neck Surgery
Facial Plastic and Reconstructive Surgery

508 S. Washington Street
Gettysburg, Pa 17325
Fax - (717)334-8172
(717)334-8171

250 Fame Avenue, Suite 201
Hanover, Pa 17331
Fax - (717)633-5552
(717)633-9229

## Payment Policy

I understand by signing this letter, I am being notified of the payment policy for this physician practice:

*Payment is due and expected at the time of service. Payment can be made by cash, check,Visa or Mastercard.
*I hereby authorize Adams Hanover ENT to furnish information to any insurance company or authorized agency specified regarding information concerning my medical care.
*For complete assessment, the physician you are seeing often times performs a procedure, such as a nasal endoscopy, flexible laryngoscopy or a test such as a hearing exam at the time of your visit. The cost of this is not included in the consultation or office visit charge. The office visit for a history and physical is not included as part of the surgical procedure. Fees for consultations, office visits, procedures and tests are dictated through our contract with your insurance company.
***The patient is responsible for all deductibles, co-payments, co-insurance and non-covered services the day of the visit.**
*For these services provided and submitted to my insurance company, I hereby authorize payment of medical benefits directly to Adams Hanover ENT.
*There will be a $30.00 charge for missed appointments and appointments not rescheduled at least 24 hours in advance.
*Any past due balances will incur a finance charge of 1.5% per month. After 90 days, accounts will be turned over to a collection agency and 33.3% collection charge will be added to the account.

I understand and agree I am ultimately responsible for payment for any professional services rendered. I have read the above policy and agree to all of the terms.

Patient's Name: _____

Signature of parent/legal guardian: _____

Date: _____

## For Medicare Patients Only

I authorize any holder of medical or other information about the above-named patient to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance and any non-covered services as determined by Medicare.

Signature of parent/legal guardian: _____

Date: _____

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____

PATIENT NAME: _____AGE: _____DOB:_____SEX: M/F
LAST FIRST MI

ADDRESS: _____ SS#_____

CITY: _____STATE:_____ZIP:_____

HOME PHONE: _(____)_____CELL: _(_____)_____

EMAIL ADDRESS: _____
PARENT/GUARDIAN INFORMATION:

FATHER'S NAME: _____ MOTHER'S NAME:_____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE: _(_____)_____ PHONE: _(_____)_____

CELL: _(_____)_____ CELL: _(_____)_____

EMPLOYER: _____ EMPLOYER: _____

PHONE: _(_____)_____ PHONE: _(_____)_____

OKAY TO CALL AT WORK: YES/NO OKAY TO CALL AT WORK: YES/NO

_____ _____

SCHOOL INFORMATION: PATIENT'S SCHOOL: _____

_____ _____

IS THIS VISIT A RESULT OF A SCHOOL OR WORK RELATED INJURY: YES/NO

IF YES: SCHOOL/WORK DATE OF ACCIDENT: _____

FIRST DAY OFF WORK/SCHOOL: _____

_____ ____

PRIMARY INSURANCE: _____SUBSCRIBER:_____

SECONDARY INSURANCE: _____UBSCRIBER:_____

_____ _____

I AUTHORIZE ADAMS HANOVER ENT TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT. I ASSIGN ALL PAYMENTS TO THE PHYSICIAN FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY CHILD. I UNDERSTAND I AM RESPONSIBLE FOR CHARGES NOT COVERED BY INSURANCE.

PARENT/GUARDIAN SIGNATURE:_____RELATIONSHIP:_____DATE:_____