ADAMS HANOVER ENT, LLC

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□ **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 YOUR INSURANCE CARD AND PHOTO ID. 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 (PCP) 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.

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.

Patient Name:_____ **Age:** ___ **Date of birth:** _____ **Today's Date:** _____
Occupation / School: _____

What is the medical issue that brought you here today? _____
_____
Symptom start date::_____ Now symptoms are ___better __worse ____same
Severity of symptoms: __mild __ moderate ___severe What therapies have you tried? _____
_____
Have you had any testing completed for this issue? ___CT ___MRI ___XRAY ___blood test ___allergy testing
Other::_____

PAST MEDICAL HISTORY: (circle all that apply)

MEDICAL PROBLEMS: ADD - ADHD - Alzheimer's Disease - Aneurysm - Angina - Anxiety - Arthritis - Asthma - Atrial Fibrillation Autism - Bipolar Disorder - Bleeding Disorder - Cataracts - Congestive Heart Failure - COPD - Crohn's - Dementia - Depression - Diabetes - Epilepsy - Fibrolmyalgia - Glaucoma - Gout - Herpes - High/Low Blood Pressure - Heart Attack - Heart Disease - Hepatitis - High Cholesterol - HIV/AIDS - HPV - Kidney Disease - Lupus - Lyme's Disease - Macular Degeneration - Multiple Sclerosis - Osteoporosis - Parkinson's - Polio - Prostate enlargement - PTSD - Reflux- Restless Leg - Sjogren's Syndrome - Sleep Apnea - Stroke - Thyroid Disease - CANCER (type:_____)
OTHER:_____

SURGERIES: Adenoidectomy - Appendectomy - Back - Breast - Carpal Tunnel - Cesarean Section - Colonoscopy - Defibrillator - Ear - EGD - Eyes - Gallbladder Removal - Gastric Bypass - Heart Catherization - Heart Bypass - Heart Stenting - Hernia - Hysterectomy - Kidney Stones - Nose - Pacemaker - Prostate - Sinus - Throat - Thyroid - Tonsillectomy - Tubal Ligation - Tubes (ear) - Vasectomy - OTHER:_____

CURRENT MEDICATIONS: (including over-the-counter, vitamins, and supplements, CPAP, oxygen, etc.)
PROVIDE A LIST OR COMPLETE BELOW:

MEDICATION/STRENGTH/FREQUENCY	REASON TAKEN
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____
8._____	_____

FOOD/DRUG ALLERGIES: None known - Penicillin - Amoxicillin - Augmentin - Cipro - Zithromax - Bactrim - Sulfa - Rocephin - Tetracycline - Novacaine - Xylocaine - Codeine - Peanuts - Shellfish - Iodine - Adhesives - Tape - Latex
OTHER:_____

Have you ever had/required blood transfusion? Yes/No Are you HIV positive? Yes/No
Are you pregnant? Yes/No Hepatitis? Yes/No Type? ____A ____B ____C ____D

SOCIAL HISTORY (Please be complete & honest)**:**

Caffeine: Coffee / Soda / Caffeine beverage(s) per day? _____
Smoking: Have you every smoked? Yes/No ___Cigarettes ___Pipe For how long? ____ years
Packs/bowls per day? ____ Do you still smoke? Yes/No If applicable, how many years ago did you quit? ____
Chewing tobacco: Have you every chewed? Yes/No For how long? ____ years Bags/Cans per day? ____
Do you still chew? Yes/No If applicable, how many years ago did you quit? ____
Alcohol: Do you drink alcohol? Yes/No ___Currently ___Previously How many drinks per day/week/year? ____
___Beer ___Wine ____Liquor/mixed drinks ___Socially ____Habitually Quit drinking? _____
Recreation/Illegal drugs: ___Currently ___Previously How much per day/week? _____
Type? Marijuana / Cocaine / Heroine / Methamphetamine / Depressants / Ecstasy / LSD / Mushrooms

Patient Name:_____ **Age:** ___ **Date of birth:** _____ **Today's Date:** _____

FAMILY HISTORY: (circle all that apply)

History of Family Illness: Bleeding Disorder - Cancer (type_____) - Diabetes - Heart Attack - Hearing Loss High Blood Pressure - Kidney Disease - Stroke - OTHER _____
FATHER: __Alive (Age:___) __Deceased: Cause:_____
MOTHER: __Alive (Age:___) __Deceased: Cause: _____

REVIEW OF GENERAL HEALTH: (Please circle **CURRENT** symptoms **ONLY)**

GENERAL: Anorexia - Anxiety - Appetite-increased - Appetite-decreased - Bedwetting - Body aches - Chills - Decreased energy - Developmental issues - Excessive daytime sleepiness - Fainting - Fatigue - Fever - Malaise - Night sweats - Nonrestorative sleep - Restless sleep - Sleep disorder - Weak feeling - Weight gain - Weight Loss

EYES: Blurry vision - Bulging eyes - Dark circles - Double vision - Drooping eyelids - Excessive tearing - Eyelid crusting - Flashing lights - Foreign body sensation - Inflammation - Irritation - Itchy - Jaundice - Light sensitive - Redness - Prothesis - Sandy feeling - Spots before eyes - Swelling of lids - Visual acuity change - Watery

EARS: Ear infections R/L - Congestion R/L - Feeling of fullness R/L - Earache R/L - Ear noise R/L - Hearing change R/L Hearing difficulty R/L - Itching R/L - Pain R/L - Pressure R/L - Ringing R/L

NOSE/SINUS: Altered smell - Bloody nose - Chronic runny nose - Congestion - Facial pain - Facial pressure - Frequest nosebleeds - Itchy nose - Mouth breathing - Polyps - Postnasal drainage - Sense of smell-decreased - Sense of smell-absent - Septal performation - Sinus infections - Sinus pressure - Sneezing - Snoring - Soreness

MOUTH: Bleeding or sore gums - Frequent yeast infections (thrush) - Lip lesions - Loose or painful dentures - Oral lesions or masses - Sense of taste-absent - Sense of taste-diminished - Sore or buring tongue - Ulcers

THROAT: Bad breath - Chronic phlegm in throat - Difficulty swallowing - Dry mouth - Enlarged tonsils - Feeling of lump in throat - Frequent clearing - Frequent sore throat - Hoarseness - Painful swallowing - Recurrent strep throat

HEART: Chest pain with walking - Chest pressure - Heart murmur - Heart racing - History of abnormal EKG - History of rheumatic fever - Irregular heartbeat - Left arm or jaw pain - Palpitations - Shortness of breath when lying down

LUNGS: Cough-dry - Cough-productive - Coughing up blood - Difficulty breathing - History of abnormal chest x-ray - History of tuberculosis - Pain with breathing - Sleep apnea - Shortness of breath - Wheezing

GASTROINTESTINAL: Abdominal pain - Change in bowel habits - Chronic heartburn - Constipation - Dark, tarry stools - Diarrhea - Food intolerance - Indigestion - Nausea - Rectal bleeding - Vomitting

GENITOURINARY: Bedwetting - Difficulty urinating - Frequent urination day/night - Frequent urinary tract infections - Recurrent kidney stones - Incontinence - Poor kidney function - Prostate enlargement - Urinary urgency

MUSCULOSKELETAL: Brittle bones - Chronic back pain - Chronic joint pain - Easily fractured - Facial fracture - Muscle cramping - Muscular weakness - Nasal fracture - Neck lump - Neck stiffness

SKIN: Bruising - Bumps - Dryness - Eczema - Hives - Itchiness - New or changing moles - Nonhealing sores - Lesion - Rash - Redness - Rosacea - Psoriasis - Thickened or enlarging scars - Ulcers

NEURO: Convulsions - Coordination difficulties - Disorientation - Dizziness - Facial weakness - Frequent headaches - Head injury - Lightheadedness - Loss of balance - Memory loss - Migraines - Muscle weakness - Numbness - Seizures - Slurred speech - Tremors - Vertigo - Weakness of hands/arms/legs

PSYCHIATRIC: Agitation - Anxiety - Alcohol abuse - Depression - Difficulty concentrating - Insomnia - Irritability - Panic Attacks - Paranoia - PTSD - Suicide attempts - Suicidal thoughts

ENDOCRINE: Changes in hair or skin texture - Chronic thirst - Diabetes - Drooping or swollen lower eyelids - Frequent urination - Goiter - Heat or cold intolerance - Increased sweating

BLOOD/LYMPH: Anemia - Bleeding disorder - Hepatitis - History of bleeding problems - History of blood clots in legs - Jaundice - Leg or ankle swelling - Leg pain when walking - Swollen lymph nodes or glands - Varicose veins

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 patient/guardian: _____

Date: _____

For Medicare Patients Only

I authorize any holder of medical or other information about me 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.

Patient/Guarantor's Signature: _____

Date: _____

Primary Care Physician: _____ Referring physician:_____

Any other physician that you would like to include on your care team who is to receive copies of testing/labwork/office visit information completed at/by Adams Hanover ENT? _____

How did you hear about us? __referring physician__family member/friend __internet __print ad in_____

Patient Name:_____ **Age:** ___ **Date of birth:** _____ **Today's Date:** _____
Last First MI
Preferred Name: _____ SS#: _____ Gender: Male/Female/Decline to specify

Race: ___White ___Black/African American ____American Indian/Alaskan Native ___Asian, Country:_____
___Native Hawaiian/Pacific Islander, Country: _____ ___Other_____ ___Decline to specify

Ethnicity: ____Hispanic/Latino ___Non-Hispanic/Latino ___Decline to specify Primary Language: _____

Address: _____

City: _____ State:_____ Zip code: _____

Home phone (____)_____ Cell/Mobile: (___)_____

Email address: _____

Employer: _____ Occupation: _____

Work phone: (_____)_____ Extension: _____ Okay to call: Yes/No

Marital Status: ___Single ___Married ___Widowed ___Divorced __Separated

Spouse's Name: _____ Spouse's Date of Birth:_____

Spouse's Employer: _____ Spouse's Occupation:_____

Emergency Contact Name: _____

Relationship: _____Phone : (____)_____ home/cell

Contact preferences: (Please check all locations that we have your permission to contact you.)
Appointment Info: May we contact you at ___Home ___Cell ___Text ___Work ___Mail ___Email ___Another person
Medical Info: May we contact you at ___Home ___Cell ___Text ___Work ___Mail ___Email ___Another person

Primary Health Insurance: _____ Subscriber name:_____

Secondary Health Insurance: _____ Subscriber name:_____

Is this visit as a result of a work-related injury? Yes/No If yes, date of injury: _____ First day off of work:_____

Is this visit as a result of an automobile accident? Yes/No IF yes, what was the date of the accident: _____

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. I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY INSURANCE.

_____ _____
Signature of patient/legal guardian/power of attorney Date