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.

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 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.

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)
PROVIDE A LIST OR COMPLETE BELOW:

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 BREATHING

MOUTH: LOSS OF TASTE PAIN DRY SORES/ULCERS BLEEDING DENTURES 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 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:_____

PATIENT NAME:_____AGE:_____ DATE OF BIRTH: _____SEX: M/F
LAST FIRST MI
MAIDEN NAME: _____ SS# _____

ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

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

EMAIL ADDRESS: _____

EMPLOYER: _____OCCUPATION: _____

WORK PHONE: _(_____)_____EXT: _____OKAY TO CALL YES/NO

MARITAL STATUS: (CIRCLE ONE)

SINGLE MARRIED

WIDOWED DIVORCED

SEPARATED

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

SPOUSE'S OCCUPATION:_____

SPOUSE'S DOB:_____

EMERGENCY CONTACT PERSON: _____

RELATIONSHIP: _____PHONE: _(____)_____

PRIMARY INSURANCE: _____SUBSCRIBER:_____

SECONDARY INSURANCE: _____SUBSCRIBER:_____

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

IF YES: DATE OF ACCIDENT: _____FIRST DAY OFF WORK:_____

IS THIS VISIT A RESULT OF AN AUTOMOBILE ACCIDENT: YES/NO

IF YES: DATE OF 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/GUARDIAN DATE_