PATIENT INFORMATION FORM

We appreciate you taking the time to fill out these forms. Please answer completely.

Full Legal Name ____ Preferred Name _________________________

Mailing Address ____ City, State, Zip _________________________________

Gender ☐ Male ☐ Female

Cell Phone ______________________ Home Phone ______________________ Work Phone ______________________

Email ____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth _____/_____/________ Age _______ SSN# ______- ______-__________

Employer ____

Primary Language ____________________________________

Which Doctor referred you to our office? (*First & Last Name*) ____

Who is your Primary Care Doctor? (*First & Last Name*) ____

Responsible Party Information (e.g., legal guardian of minor)

This section needs to be filled out **ONLY** if the patient is age 17 years and younger.

Parent/Guardian Name ____

Mailing Address ____ City, State, Zip _________________________________

Gender ☐ Male ☐ Female

Date of Birth _____/_____/________

Primary Phone ______________________

Employer ____

Patient's Relation to Responsible Party ____

Health Insurance Information

Despite providing your insurance cards, this section needs to be filled out completely to ensure we can bill your insurance correctly.

Is the patient insured? ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Company _________________________________

Address ____

Subscriber Name ___________________________________

Subscriber Date of Birth _____/_____/________

Subscriber ID ______________________________________

Group # ____

Patient's Relation to Subscriber ________________________

SECONDARY INSURANCE

Insurance Company _________________________________

Address ____

Subscriber Name ___________________________________

Subscriber Date of Birth _____/_____/________

Subscriber ID ______________________________________

Group # ____

Patient's Relation to Subscriber ________________________

Emergency Contact *(not living with you)*

Name __________________________________Relation __________________________ Phone______________________

Mailing Address ____ City, State, Zip _________________________________

Release of Medical Information / Authorization to Treat in the Absence of Legal Guardian

I authorize the doctors and staff at this medical practice and its affiliates to disclose protected health information such as office notes and diagnostic test results to the below-named persons (e.g., spouse or parent). Furthermore, I consent for my child or dependent to be treated in my absence when brought into the office by the below-named persons and as indicated by the checked box. This authorization shall be effective until I revoke it in writing.

Individual # 1 ____________________________________
Relation to Patient ________________________________
Phone ____

☐ Treatment in Absence

Individual #2 ____________________________________
Relation to Patient ________________________________
Phone ____

☐ Treatment in Absence

Notice of Privacy Practices

I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices (*find a copy on the Patient Info page of our website*).

Initials ___________

Self-Pay Agreement

A Self-pay patient is defined as a patient who (1) has no health insurance coverage of any kind or (2) cannot provide proof of insurance (i.e., insurance ID card) at the time of service. The self-pay cost of all medical services will be collected in advance or at the time of service of office visits, diagnostic tests, and surgical procedures. Any recommended diagnostic tests or procedures (lab/blood tests, hearing tests, CT scans, ultrasounds, biopsies, etc.) have a separate cost. I understand that if I do not pay for services on the day performed, this office will bill me directly for the entire cost of those medical services.

*****If I have any questions about this policy, I have the right to speak to the Billing Department for details*****

I acknowledge that I have read the above Self-Pay Agreement, understand its terms, and agree to comply with its terms.

Initials ___________

Financial Policies

I understand co-payments are due at the time of service. I understand that some medical services performed in the office such as hearing tests, lab tests, ultrasounds, CT scans, biopsies, endoscopies, ear cleanings, and other procedures are billed separately from the office visit. I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as “non-medically necessary” by my insurance carrier. I am responsible for providing correct/updated insurance information so this medical practice can bill my insurance. If payment in full is not made as required, then in addition to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Peak ENT Associates or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgment). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Peak ENT Associates or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily--meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.

I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Peak ENT Associates by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Peak ENT Associates or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial messages and/or the use of an automated dialing device and/or the use of text messages—

some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.
I acknowledge that I have read, understand, and agree to the terms of the Financial Policies stated above.

Initials __________

Consent for Treatment

I voluntarily consent to medical care and examination at this medical practice and its affiliates and by its physicians, clinicians, and other personnel. I understand that the practice of medicine is not an exact science and no guarantee has been or can be made as to the results of medical care or examinations.

Initials __________

Card On File

I, the undersigned patient or legal guardian of the patient named above, hereby authorize PEAK ENT ASSOCIATES to keep my credit/debit card information on file for the purpose of payment for healthcare services rendered. I understand and agree to the following terms and conditions:

1. **Authorization:** I authorize PEAK ENT ASSOCIATES to securely store my credit/debit card information on file.
2. **Payment Authorization:** I authorize PEAK ENT ASSOCIATES to charge my card on file for any outstanding balances automatically up to $100 a month or with my authorization above said amount, related to services provided by PEAK ENT ASSOCIATES.
3. **Security:** I understand that PEAK ENT ASSOCIATES will maintain the confidentiality and security of my credit/debit card information in compliance with HIPAA regulations and industry standards.
4. **Billing Statements:** I acknowledge that I may request a statement for any charges processed using the card on file.
5. **Card Updates:** I agree to notify PEAK ENT ASSOCIATES promptly of any changes to my card information, such as expiration date, card number, or billing address.
6. **Declined Payments:** I understand that PEAK ENT ASSOCIATES will charge a $20 declined fee if the payment is declined.
7. **Revocation of Authorization:** I understand that I may revoke this authorization at any time by providing written notice to PEAK ENT ASSOCIATES. However, revocation of this authorization will not affect charges incurred before the revocation.

I have read and understood the terms outlined above and voluntarily consent to have my credit/debit card information kept on file by PEAK ENT ASSOCIATES for the purposes stated.

Initials __________

By signing below, I agree to the terms of the initialed sections above: *Release of Medical Information, Notice of Privacy Practices, Self-Pay Agreement, Consent for Treatment, Financial Policies, and Card on File.*

Signature___________________________________ Date ____/____/______ Relation to patient________________________

MEDICAL HISTORY FORM

Name:___________________________________ Age:_______ Date of Birth_____/_____/________

Date symptoms started:______________________ Primary reason for visit:_______________________________

LIST ALL DIAGNOSED MEDICAL CONDITIONS

☐ Hypothyroidism ☐ Hyperthyroidism
☐ Thyroid Nodules ☐ Parathyroid disorder
☐ Thyroid Cancer

____

____

____

____

____

Can we please add an other tab?

LIST ALL PREVIOUS SURGERIES

☐ Thyroidectomy: *(date)*______________________________

☐ Parathyroidectomy: *(date)*__________________________

☐ Hysterectomy: *(date)*________________________________

☐ Weight loss surgery: *(date)*__________________________

____

____

____

Can we please add an other tab?

SOCIAL HISTORY *(check all that apply)*

☐ Alcohol use: _____ drinks per week ☐ No Alcohol use

☐ At risk for HIV infection
(unprotected sex, IV drug use, history of blood transfusions)

☐ History of drug use

Smoking Status: ☐ Current If current: _____ packs per day
☐ Former (when quit: _________)
☐ Never smoked

Second hand smoke exposure:
☐ Environmental ☐ Occupational ☐ Perinatal/before birth

☐ Tobacco use (other/chew): ________________________

Preferred Pharmacy:_________________________________
(Name, City)

LIST ALLERGIES TO MEDICATIONS: ☐ No Known Allergies

____

____

LIST CURRENT MEDICATIONS & SUPPLEMENTS:
(use back of this form for more space)

Name	Dose	Frequency	Route (oral, injection, etc.)

MEDICAL HISTORY FORM...continued

Name:_________________________________ Date of Birth_____/_____/________

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
☐ Diabetes	______________________
☐ Thyroid/Parathyroid disorders	______________________
☐ Thyroid cancer	______________________
☐ Other cancer	______________________
☐ Heart disease	______________________
☐ Bleeding tendency	______________________

☐ None of the above

REVIEW OF SYSTEMS

CHECK □ ALL THAT APPLY (Problems you have had within the past 3 months)

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitation or heart racing
- ☐ Swelling in legs or feet

EAR NOSE THROAT

- ☐ Dizziness
- ☐ Hoarseness

ENDOCRINE

- ☐ Breast discharge
- ☐ Excessive thirst
- ☐ Heat or cold intolerance

EYES

- ☐ Double vision
- ☐ Loss of vision

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea or vomiting

GENERAL

- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change

INTEGUMENTARY (Skin)

- ☐ Changes in hair or nails
- ☐ New stretch marks

MUSCULOSKELETAL

- ☐ Hip pain
- ☐ Muscle cramps

NEUROLOGIC

- ☐ Frequent headaches
- ☐ Numbness around mouth
- ☐ Tremors

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression

RESPIRATORY

- ☐ Frequent cough
- ☐ Shortness of breath

☐ I have none of the above symptoms

I have reviewed the above and checked all symptoms which apply.

Patient/Representative Signature:______________________________ Today's Date:______________________