Ohio ENT & Allergy Physicians
PEDIATRIC AND ADULT

Patient Name_____ DOB_____ Sex ☐ M ☐ F

Social Security_____ Race_____

Ethnicity_____ Preferred Language_____

Marital Status_____ Employer_____

Address_____ Please check one box to indicate preferred number

City/State/Zip_____ ☐ Home Phone_____

Email_____ ☐ Cell Phone_____

Emergency Contact & Phone_____ ☐ Work Phone_____

Primary Care/Pediatrician/Referring Physician(Provider that requested you see a Ohio ENT & Allergy Physicians)

Name_____ Practice Name_____

Address_____ Phone_____

City/State/Zip_____ Fax_____

Parent/Guarantor Information Please complete for all responsible parties

Name_____ Name_____

Relationship to Patient_____ Relationship to Patient_____

Social Security_____ DOB_____ Social Security_____ DOB_____

Address_____ Address_____

City/State/Zip_____ City/State/Zip_____

Home Phone_____ Home Phone_____

Work Phone_____ Work Phone_____

Can you receive calls at work? ☐ Yes ☐ No
May we leave you a voice mail? ☐ Yes ☐ No

Can you receive calls at work? ☐ Yes ☐ No
May we leave you a voice mail? ☐ Yes ☐ No

Email_____ Email_____

Occupation_____ Occupation_____

Employer_____ Employer_____

Insurance Information

Insurance Name_____ Secondary Name_____

ID/Group_____ ID/Group_____

Subscriber Name_____ Subscriber Name_____

Subscriber DOB_____ Subscriber DOB_____

Relationship to patient_____ Relationship to patient_____

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PATIENT QUESTIONNAIRE

Please fill out this form completely

Patient Name_____ DOB_____

Primary Care Physician:_____ Referred by:_____

Other family members seen in our office_____

Current Medications-(Please look at bottle or packaging as many names sound and are spelled similarly. Use a separate sheet of paper if necessary)

Medication Name	Dose	How often	Duration Taken

Other Allergy Medication Tried or used in the past	Name	Did it work? Y/N

Medication Allergies ☐ **No Known Drug Allergies**

Drug Name	Reaction	When?

Past Medical History/Problems: *(check all that apply)*

☐	Asthma	☐ Deafness	☐	Heart Murmur	☐	Tuberculosis	■ **CANCERS**
☐	Angina	☐ Depression	☐	High Blood Pressure	☐	Thyroid disease	☐ Head/Neck
☐	Anemia	☐ Diabetes	☐	Hepatitis	☐		☐ Lung
☐	Arthritis	☐ Emphysema	☐	Hemorrhoids	■	**MEN ONLY**	☐ Breast
☐	Bleeding Problems	☐ Glaucoma	☐	Kidney stones	☐	Prostate problem	☐ Stomach
☐	Broken Bone	☐ Gallstones	☐	Rheumatic Fever	■	**WOMEN ONLY**	☐ Colon
☐	Cataracts	☐ Gout	☐	Stroke	☐	Menstrual Problems	☐ Liver
☐	Chronic Bronchitis	☐ Goiter	☐	Stomach Ulcer	☐	Breast Cancer	☐ Lymphoma
☐	Cirrhosis	☐ Heart Attack	☐	Skin Problems	☐	Other GYN issues	☐ Leukemia

Personal Medical History:

Have you ever seen an allergist before? Yes☐ No☐ Who?_____
Have you ever had allergy skin testing? Yes☐ No☐ When?_____
Have you ever been given allergy shots? Yes☐ No☐ When?_____

Please list any surgeries you have had:_____
_____
_____

Do you smoke: Y☐N☐ If yes, how much?_____ How long?_____

Does anyone else smoke in your home? Y☐ N☐

Do you drink alcohol? Y☐N☐ If yes, how many per week? Beer___ Wine___ Liquor___

Have you ever had an allergic reaction to a food? Y☐ N☐ What?_____

Have you ever had an allergic reaction to an insect bite? Y☐ N☐ When?_____

OTHER HISTORY:

Occupation: _____

Are you exposed to any chemicals or fumes at work? Y☐ N☐ What?_____

Do you have any pets in your home? Y☐ N☐ What?_____

Do you have mold or mildew in your home? Y☐ N☐

Do you have air conditioning? Y☐ N☐ Do you have a basement? Y☐ N☐

Do other family members have allergies?_____

Have you *recently* had any of the following? (Check all that apply, if in doubt, leave blank)

GENERAL
☐Fatigue
☐Weight loss
☐Weight Gain
☐Night sweats
☐Fever
☐Sleep apnea
☐Recurrent Infections

SKIN
☐Rash
☐Hives
☐Itching
☐Swelling
☐Bruising

EYES
☐Itching
☐Dryness
☐Eye pain
☐Red eyes
☐Vision Changes

NOSE
☐Bloody Nose
☐Congestion
☐Runny Nose
☐Sinus Infections
☐Polyps

EARS
☐Ear infections
☐Hearing loss
☐Ringing
☐Vertigo

MOUTH/THROAT
☐Sore Throat
☐Lip Swelling
☐Tongue Swelling
☐Throat Itching

ENDOCRINE
☐Tremor
☐Heat/Cold Intolerance

BLOOD
☐Easy Bleeding
☐Bruising

HEART/LUNGS
☐Wheezing
☐Shortness of Breath
☐Persistent cough
☐Bronchitis
☐Frequent Pneumonia
☐Palpitations
☐Chest Pain
☐Heart Murmur
☐High Blood Pressure

STOMACH/ INTESTINES
☐Heartburn
☐Nausea
☐Upset stomach
☐Vomiting
☐Abdominal Pain
☐Diarrhea
☐Constipation

GENITOURINARY
☐Urinary Tract Infections
☐Blood in Urine
☐Incontinence

OB/GYN
☐Vaginal Infections
☐Estrogen Therapy
Number of Children____

MUSCULOSKELETAL
☐Joint Pain
☐Joint Swelling
☐Muscle weakness

NEUROLOGIC/ MENTAL HEALTH
☐Headaches
☐Seizures
☐Numbness/Tingling
☐Depression
☐Nervousness
☐Anxiety

Medication History Consent

I authorize Ohio ENT and Allergy Physicians to gather my electronic medication history view via my pharmacy records and my insurance benefit management company records. _____ or I decline: _____
Initial Initial

Assignment of Benefits

I acknowledge financial responsibility for all facility and physician/provider fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician for all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carriers and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance's timely filing limit. _____
Initial

Receipt of Notice of Privacy Practices

I have received the practice's Notice of Privacy. Photocopies of this document are to be as valid as the original. _____
Initial

Telephone Consumer Protection Act

I authorize Ohio ENT and Allergy Physicians and any entity authorized by Ohio ENT and Allergy Physicians including those using automated dialing systems, automated messages, email, text messaging or other electronic communications to contact me for any reason by using any telephone number, email or mailing address I provide. _____ or I decline: _____
Initial Initial

Communication Preferences Regarding Protected Health Information

To assist in your care it may be necessary to release Protected Health Information (PHI) to someone other than yourself. To whom may we speak about your care? Please list names to right of relationship.

Yes	No	
☐	☐	Spouse_____
☐	☐	Parent/Step Parent_____
☐	☐	Caregiver_____
☐	☐	Other_____

May we leave a message on:

Yes	No	
☐	☐	Your answering machine/voicemail at home
☐	☐	Your answering machine/voicemail at work

_____
Patient Name

_____
Patient or Representative Signature Date

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be paid to University Otolaryngologists Inc dba Ohio ENT an Allergy Physicians for any services furnished to me by one of their physicians or other medical providers. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me necessary to determine payments for related services.

This authorization shall remain in effect for my lifetime or until I choose to revoke it.

Print Medicare Beneficiary Name	Medicare Identification Number
Signature of Medicare Beneficiary	Date

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Appointment Cancellation and No Show Policy

Ohio ENT and Allergy Physicians is privileged to provide medical and surgical treatment to our patients. We work diligently to maintain a high level of personalized service and strive to accommodate patient needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for you, our patient, just as they do for us. However when a patient cancels an appointment without adequate notice or fails to keep an appointment we cannot use that time to service the needs of other patients. We respectfully request your understanding and agreement to our policy as it is stated below.

New Patients

We will give you a reminder call 48 hours in advance of your scheduled appointment. Any new patients who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours prior to the appointment will be required to pay a fee of $35.00 in order to schedule a new office visit. For Monday appointments cancellations must be made by noon on the proceeding Friday. This fee must be paid prior to your next appointment.

Established Patients

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance will be charged a fee of $20.00 per occurrence. For Monday appointments cancellations must be made by noon on the proceeding Friday.

If an established patient fails to keep three appointments, or fails to give adequate notice on three occasions, the practice has the right to dismiss that patient.

Fees

All fees charges by Ohio ENT and Allergy Physicians pursuant to this policy are not payable by your insurance company.

All fees are payable on or before your next visit or within 30 days of receipt of a billing statement for the fee, whichever is earlier.

Your physician may waive your fee for good cause. To request your fee be waived you must email a written explanation to: nsappeal@ohpin.com Please enter your physician's name in the subject line of the email. If you do not have email access you may write a letter to N/S appears, 1810 Mackenzie Dr, #2, Columbus OH 43220.

_____

Patient Signature Date