SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

To our new patients:

Welcome to Southwest Idaho Ear Nose and Throat. Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. In order to expedite the check-in process for your appointment, we have included the necessary forms for you to complete in advance.

Please fill out your paperwork completely and bring it with you to your appointment, arriving 15 minutes early. If desired, you may fax your paperwork to our office at (208) 367-3979 prior to your appointment. Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This also includes Medicare and Medicaid. If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled. Financially, payment will be required at the time of service for your portion of the charges (co-pay and deductible amounts).

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family. Thank you for choosing Southwest Idaho Ear Nose and Throat.

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FINANCIAL POLICY

Our practice is committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to know what services are covered under their insurance policy. **Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts.** We are not affiliated with any hospital, and we are unable to accept their approval for financial assistance. We do not offer a sliding fee scale for our charges. If you require financial assistance from our office or want to arrange a payment plan, please contact our billing office at (208) 367-6950. We accept cash, check, Visa, Mastercard, American Express, Discover and CareCredit.

If you do not cancel 24 hours prior to your appointment time or arrive to your appointment more than 15 minutes late, you will be charged a no-show fee of $50.

Southwest Idaho Ear Nose and Throat, PA uses third party agencies to collect on accounts that are past due. Returned checks are subject to an additional fee and will be sent to a third-party agency if not paid in full after receiving notification.

The physicians at Southwest Idaho Ear Nose and Throat may need to perform additional testing during your visit. In order to accurately diagnose and treat your medical condition, your physician may prescribe diagnostic tests such as hearing and balance tests, nasal endoscopy, laryngoscopy, CT scans, biopsies and/or other diagnostic testing including cerumen removal (ear cleaning). Each insurance policy processes these tests differently, and charges may be applied to your deductible and/or co-insurance or co-pay. Every effort will be made to obtain any required authorization prior to your testing. If you wish to discuss charges prior to testing, please ask to speak with the billing staff.

I authorize the release of any information necessary to determine liability for payment or obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled, including private insurance and other health plans, to Southwest Idaho Ear Nose and Throat, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges that are not paid by insurance including all diagnostic testing.

I hereby authorize Southwest Idaho Ear Nose and Throat, PA to appeal any incorrect insurance payment. I release Southwest Idaho Ear Nose and Throat, PA from all legal responsibility or liability that may arise from this authorization. **I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.**

Signature _____ Date _____
Responsible Party Signature

HIPAA Notice of Privacy Practices
I acknowledge the receipt of Southwest Idaho ENT, PA's notice of privacy practices.
Signature _____ Date _____

Is your visit the result of accident? YES ☐ NO ☐ Date of Injury: _____ Description: _____

Is this a Worker's Compensation claim? YES ☐ NO ☐ Claim Number: _____

SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____ Age _____ D.O.B. _____

Email Address _____ Marital Status ☐ M ☐ S ☐ D ☐ W

Primary Care Physician _____ Referring Physician _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐ Hispanic or Latino

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred Language _____

Patient's Employer _____

Spouse's Name _____ D.O.B. _____ Employer _____

Work Phone _____ If Applicable, Patient's Legal Guardian _____

Father's Name (IF MINOR) _____ D.O.B. _____

Father's Home Address _____ City, State, Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name (IF MINOR) _____ D.O.B. _____

Mother's Home Address _____ City, State, Zip _____ Phone _____

Mother's Employer _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

To whom may we disclose your health information (e.g. appointment times, test results, financial) if you are not available?

Name _____ Relationship _____

Whom may we contact in case of an emergency?

Name _____ Relationship _____ Phone _____

SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

PHH Adult

Patient's Name _____ D.O.B. _____

Referring Physician _____

For Women: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly/Not Sure

Name and location of pharmacy used _____

What are you seeing the doctor for today? _____

List all current medications, including any over-the-counter (OTC) medications or supplements.
(If needed, please provide on separate sheet.)
☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take.
☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Do you have a known allergy to any of the following? ☐ None

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other (Please describe) _____

Allergies
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin/Blood
☐ Negative
☐ Testing Location
_____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
(Please Describe)
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
_____
_____
_____

Describe Reaction _____
_____
_____

SOLV F PHH ADULT 9/17

Past Health History

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor.

☐ **No Major Illnesses**

1. Childhood Diseases
- ☐ Mumps
- ☐ Measles
- ☐ Chicken Pox
- ☐ Other _____

2. Cancer
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Leukemia
- ☐ Other _____

3. Congenital (Birth) Problems
- ☐ Down Syndrome
- ☐ Heart Defect
- ☐ Prematurity (# of weeks _____)
- ☐ Other _____

4. Ears
- ☐ Chronic or Frequent Infection
- ☐ Fluid
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Other _____

5. Nose and Sinuses
- ☐ Chronic Sinusitis
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Allergies
- ☐ Other _____

6. Mouth and Throat
- ☐ Chronic Tonsillitis
- ☐ Cleft Palate
- ☐ Sleep Apnea
- ☐ Other _____

7. Heart
- ☐ Atrial Fibrillation
- ☐ Chest Pain/Angina
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Pace Maker
- ☐ Other _____

8. Lungs
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Cystic Fibrosis
- ☐ Other _____

9. Digestive
- ☐ GERD/Reflux
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Other _____

10. Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

11. Neurologic
- ☐ Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Other _____

12. Glands and Hormones
- ☐ Diabetes
- ☐ Thyroid Problem
- ☐ Other _____

13. Blood Disorder
- ☐ Low White Blood Cell Count
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Low Platelets
- ☐ Other _____

14. Immune Disorder
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's
- ☐ CREST
- ☐ HIV
- ☐ Other _____

15. Psychiatric History
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Schizophrenia
- ☐ Other _____

History of any other condition not listed?

Surgeries/Injury

Have you ever had problems with anesthesia (being put to sleep for surgery)? ☐ No ☐ Yes What problem? _____

Indicate any major surgeries (if you choose OTHER please describe).

☐ *No Surgery*

Eyes	☐ Cataract ☐ Eyelid Surgery ☐ Tear Duct ☐ LASIK ☐ Other:
Ears	☐ Tubes ☐ Ear Drum ☐ Mastoid ☐ Other:
Nose	☐ Septoplasty ☐ Rhinoplasty ☐ Sinus Surgery ☐ Other:
Throat	☐ Adenoidectomy ☐ Tonsillectomy ☐ Other:
Neck	☐ Thyroidectomy
Heart	☐ Angioplasty ☐ Bypass ☐ Valve ☐ Stent ☐ Other:
Digestive	☐ Appendectomy ☐ Gallbladder ☐ Hiatal Hernia ☐ Other:
Female Health	☐ Hysterectomy ☐ Ovary Removal ☐ Other:
Other	☐ Any other major surgery:

Serious injury? ☐ No ☐ Yes Please Describe _____

Family History

☐ Family History Unkown

Do any of your BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia
☐ Hearing Loss After Age 20
☐ Heart Problem
☐ Cancer
☐ Other Major Health Problems
Please Describe _____
☐ No Family History Problems Known

Social History

Current Occupation _____ ☐ Retired ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Quit ☐ Yes: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Vape

How many per day? _____

When did you start? Age _____ or Year _____ When did you stop? Age _____ or Year _____

Alcohol Use: ☐ Yes ☐ No

How many drinks per week on average? _____

Have you ever been dependent on or addicted to any drugs? ☐ Yes ☐ No

Tests and Immunizations

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64, when was your most recent cervical cancer screening (pap test)?
   N/A or date _____

2. If you are a female patient between the ages of 42-69, when was your most recent breast cancer screening (mammogram)?
   N/A or date _____

3. If you are a patient between the ages of 50-75, when was your most recent colorectal cancer screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date _____

4. If you are a patient 65 years or older, when was your most recent pneumonia vaccination administered?
   N/A or date _____

5. If you are a patient 6 months or older, when was your most recent influenza immunization administered?
   N/A or date _____

Patient Signature _____ Date _____