CARLSON
EAR NOSE & THROAT ASSOCIATES

HEALTH QUESTIONNAIRE

NAME_____SEX_____AGE_____DOB_____HEIGHT_____WEIGHT____

PLACE OF BIRTH_____REASON FOR VISIT_____

LIST OF MEDICATIONS: (IF ADDITIONAL SPACE IS NEEDED, PLEASE CONTINUE ON THE BACK OF THIS PAGE)

DRUG	DOSE	FREQUENCY	YEAR STARTED

OTC MEDICATIONS (E.G. VITAMINS)_____

History of Drug Abuse? _____ HIV Test? _____ Positive or Negative?_____

MRSA Test?_____ Year?_____ Positive or Negative?_____

ALLERGIES (MEDICATIONS, FOOD, SEASONAL)_____

Preferred Pharmacy/ Cross Streets_____

CAT SCAN OR MRI YEAR_____ LOCATION_____ RESULTS_____

OF HEAD OR NECK YEAR_____ LOCATION_____ RESULTS_____

FAMILY HISTORY

	FATHER	MOTHER	SISTERS	BROTHERS	OTHERS
Hearing Loss	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Ringing in Ears	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

PERSONAL PAST MEDICAL HISTORY

(IF ADDITIONAL SPACE IS NEEDED, PLEASE CONTINUE ON THE BACK OF THIS PAGE)

SURGERIES	TYPE	LOCATION	YEAR

Review of Symptoms CIRCLE ALL THAT APPLY TO YOU:

	Swollen Neck	Palpitations	Gonorrhea	Migraine Headache
Hearing Loss	Swollen Glands	Varicose Veins		Fatigue
Dizziness	Heartburn	Irregular Pulse	Arthritis	
Ringing in the Ears			Gout	Asthma
Ear Drainage	Diff. Swallowing	Jaundice	Recent Weight---	COPD
Ear Pain	Hoarseness		Loss	Shortness of
TMJ Syndrome	Thyroid Disease	Kidney Stones	Cancer	Breath
		Colitis		
Nose Bleeds	Cataracts	Hepatitis	Easy Bleeding	
Nasal Drainage	Vision Problems	Diabetes	Bruise Easily	
Nasal Polyps		Prostate problems	Anemia	Beer Use
Headaches	Hypertension			Wine Use
	Coronary Heart---	Herpes	Depression	Alcohol Use
Sore Throat	Disease	Venereal Disease	Mental Illness	
	Heart Murmur	Chlamydia	Seizures	Cigarette/Cigar

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Tucson, AZ 85712
(520) 795-8777
(520) 795-8787 Fax

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PATIENT INFORMATION

NAME: LAST_____ FIRST_____ M.I._____

DATE OF BIRTH_____ S.S.#_____ MAIDEN NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ WORK PHONE_____

OCCUPATION:_____E-MAIL ADDRESS_____

PRIMARY CARE PHYSICIAN_____REFERRED BY_____

IS THIS ACCIDENT/WORK RELATED? ____YES_____NO_____

NURSING FACILITY? YES, INFO: _____NO_____

NAME OF PRIMARY INSURANCE HOLDER

NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____S.S.#_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ Phone_____

EMPLOYER_____ ADDRESS_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____

SUBSCRIBER ID NUMBER_____

GROUP NUMBER_____ SUBSCRIBER'S NAME_____

NAME OF SECONDARY INSURANCE HOLDER

NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____S.S.#_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

EMPLOYER_____ ADDRESS_____

SECONDARY INSURANCE INFORMATION / IS THIS CROSS OVER ACCOUNT FROM MEDICARE ?

INSURANCE COMPANY NAME_____

SUBSCRIBER ID NUMBER_____

GROUP NUMBER_____ SUBSCRIBER'S NAME_____

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EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____

CONSENT FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE JAMES R. CARLSON, MD. TO TREAT (PATIENT'S NAME)

_____

RELATIONSHIP TO PATIENT_____SIGNATURE_____ DATE_____

All patient visits of a minor (less than 18 yrs.) must be accompanied by parent or legal guardian.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have received a copy of Carlson Ear Nose and Throat Associates' Notice of Privacy Practices. This notice describes how Dr. James Carlson, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding health information.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Relationship to patient

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By signing below, I give my consent for Carlson Ear Nose and Throat Associates to disclose my record for treatment, payment and healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that this office has already taken action in reliance thereon. Additionally, this form allows me to identify restrictions on the disclosure of my records. These restrictions will affect the way health information can be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that if Dr. Carlson does not agree with the specified restrictions and feels that appropriate care cannot be given with the specified restrictions, they have the right to refuse treatment.

As part of my healthcare, I understand that oral communication is important and that if I do not specify individuals to whom my information may be released to, Carlson Ear Nose and Throat Associates will not disclose this information under any circumstance without a written authorization.

In my absence, Carlson Ear Nose and Throat Associates may discuss my medical condition with the following individuals:

_____ _____
Name/Relationship to Patient Name/Relationship to Patient

_____ _____
Name/Relationship to Patient Name/Relationship to Patient

☐ I agree that Carlson Ear Nose and Throat Associates may leave detailed messages regarding my medical condition at the following phone number(s)
_____

☐ I do not wish to have messages left with individuals or answering machines.

☐ Additional restrictions for the use or disclosure of my health information:
_____
_____

☐ No restrictions are in place at the time of signing this consent.

_____ _____
Patient's Printed Name Patient's Signature

_____
Date

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OUR CREDIT POLICY

Carlson Ear Nose and Throat Associates will charge a late payment on any part of the "Balance Forward" as shown on the monthly statements which remain unpaid 30 days or more after the first billing date. The ANNUAL PERCENTAGE RATE is approximately 10% per annum. You will be responsible for any collection fees incurred by Carlson Ear Nose & Throat Associates.

All payments shall be first applied to any late payment charge assessed on the account and then to the oldest charges unpaid, then to any current charges.

You are responsible for payment of your account balance regardless of your insurance coverage. We cannot accept responsibility for negotiating settlement with your insurance on a disputed claim. Notwithstanding insurance benefits that may have accrued, the late payment charges set out above shall be assessed against all accounts, even if the account will ultimately be paid wholly or partly by insurance benefits. **WE DO NOT CURRENTLY ACCEPT WORKERS COMPENSATION, THIRD PARTY BILLING, OR STATE FUNDED MEDICAL PLANS SUCH AS AHCCCS, MERCY CARE, ETC.**

FINANCIAL AGREEMENT AND VERIFICATION

The undersigned agrees, whether he/she signs this form as a patient or an agent of the patient, that in consideration of the services to be rendered by Carlson Ear Nose and Throat Associates, he/she obligates himself/herself to pay the account in full within 30 days of the billing date, and with the regular rates and terms, which are subject to change without notice. Self pay patients are expected to pay in full at the time of service. In the event this account is referred for collection, the patient or patient's agent shall pay reasonable attorney's fees and collection expenses. We have the option to report your account status to any credit reporting agency such as a credit bureau. I have read and understand the information on this form and approve the annual percentage rate, the method of computing the late charges, and all other terms. I certify the information given is correct to the best of my knowledge.

Patient/Agent Signature: _____Date:_____

INSURANCE RELEASE

I authorize Carlson Ear Nose and Throat Associates to release any medical information or other information to my insurance company in the course of my examination or treatment. I also request payment of government benefits to either myself or the party accepting assignment.

Patient/Agent Signature: _____Date:_____

INSURANCE AGREEMENT

I authorize Carlson Ear Nose and Throat Associates to file insurance claims on my behalf for the services rendered and accept payments from my insurance carrier(s). I realize I am responsible for the full charges incurred on my account regardless of insurance coverage.

Patient/Agent Signature: _____Date:_____

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The Epworth Sleepiness Scale

Please rate the following on a scale from 0-3
0 – no chance of dozing
1 – slight chance of dozing
2 – moderate chance of dozing
3 – high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e. theater, meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	

Total Epworth Score: _____

NAME: (please print)_____

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July 7, 2010

Regarding Payment Policy

As of November 2009, Carlson ENT instituted collection of fees at the time of service. Per insurance carrier guidelines Carlson ENT is required to collect fees that are deemed patient responsibility by their insurance carrier. This includes deductibles, co-insurance and/or co-payments. These fees are obtained online immediately prior to your appointment.

Thank you for your attention to this matter. If you have any questions, please do not hesitate to contact the billing department.

Carlson Ear Nose and Throat Associates
Medical Billing Department