Iowa Head and Neck, PC

PATIENT INFORMATION

Patient #:	**Date of Birth:**
Name:	**Social Security #:**
Address:	**Sex:** **Marital Status:**
City:	**Race:** *Circle one: (White/Asian/African American/ American Indian/More than one race/Other/Refused to Report)*
State: **Zip:**	**Ethnicity:** *Circle one: (Not Hispanic or Latino/ Hispanic or Latino/Refused to Report)*
Home Phone#:	**Language:** *Circle one: (English/Spanish/Other)*
Work Phone#:	**Emergency Contact:**
Cell Phone#:	**Emergency Phone#:**
Email:	**Parent's Name if Minor:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
City:	**Employer:**
State: **Zip**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Group Name:	**Group Name:**
Effective date:	**Effective date:**
Subscriber Name:	**Subscriber Name:**
Subscriber Birth date:	**Subscriber Birth date:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to Iowa Head and Neck, PC when assignment is accepted

Authorization To Release Medical Information. I hereby authorize Iowa Head and Neck, PC to release any information necessary for my course of treatment.

______________________________ ____________________

Signed (patient or parent if minor) Date

NAME: ______________________ **DATE OF BIRTH:** __________ **DATE:** __________

WHO SENT YOU TO SEE DOCTOR: ______________________

REASON FOR SEEING DOCTOR: ______________________

Since this problem started, have you had any of the following? (Please answer all questions by circling Yes or No)

Symptom			Symptom		
Weight loss (Amount lbs. since)	Yes	No	Neck pain	Yes	No
Weight gain (Amount lbs. since)	Yes	No	Heartburn	Yes	No
Fever	Yes	No	Vomiting	Yes	No
Allergy Symptoms: Sneezing, Watery eyes, Runny nose	Yes	No	Nausea	Yes	No
Ear pain	Yes	No	Swelling of lymph nodes	Yes	No
Ringing in one or both ears	Yes	No	Frequent urination	Yes	No
Loss of hearing	Yes	No	Dizziness / Lightheadness	Yes	No
Change in taste or smell	Yes	No	Headaches	Yes	No
Change in voice or hoarseness	Yes	No	Blurred Vision or Double Vision	Yes	No
Shortness of breath / Difficulty breathing	Yes	No	Stiffness, pain, or swelling of joints	Yes	NO
Cough	Yes	No	Skin rash or other skin problems	Yes	No
Sore throat	Yes	No			

ALLERGIES TO MEDICATIONS: ☐ YES ☐ NO What? ______________________

OTHER ALLERGIES: ☐ YES ☐ NO What? ______________________

CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER MEDICATIONS):

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

SURGERIES, HOSPITALIZATIONS AND APPROXIMATE DATES:

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

BROKEN BONES OR OTHER INJURIES: ______________________

HAS ANYONE EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING: (CIRCLE YES OR NO)

DIABETES	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	HEART DISEASE	YES	NO
STOMACH ULCERS	YES	NO	HIGH BLOOD PRESSURE	YES	NO	LUNG DISEASE	YES	NO
STROKE	YES	NO	HIATAL HERNIA	YES	NO	CANCER	YES	NO
ASTHMA	YES	NO	THYROID DISEASE	YES	NO	SLEEP APNEA	YES	NO

OTHER SERIOUS HEALTH PROBLEMS (PLEASE LIST): ______________________

HABITS (PAST OR CURRENTLY) (CIRCLE YES OR NO)

Smoke currently? **YES NO** Packs per day________for________years. Tobacco type______________

Quit smoking? If so, when?______________ Second hand smoke exposure? **YES NO**

Alcohol **YES NO** Amount______________ Duration______________

Coffee/Caffeine **YES NO** Amount______________ Duration______________

Illegal Drugs (Marijuana, Cocaine, Meth, Other) YES NO Duration, type used and amount______________

IS THERE A HISTORY OF CANCER OF THE HEAD OR NECK IN YOUR PARENTS?	**YES**	**NO**	**IF YES, MOM OR DAD**
IS THERE A HISTORY OF HEARING LOSS IN YOUR PARENTS	**YES**	**NO**	**IF YES, MOM OR DAD**
IS THERE A HISTORY OF ALLERGIES IN YOUR PARENTS	**YES**	**NO**	**IF YES, MOM OR DAD**

SIGNATURE OF PATIENT OR INDIVIDUAL COMPLETING FORM: ______________________

IOWA HEAD AND NECK, P.C.

Acknowledgement of Notification of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Iowa Head and Neck, P.C., Notice of Privacy Practices. Iowa Head and Neck, P.C. is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Brochure of full HIPAA Privacy Act is available in the waiting room.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I may request a copy of the Notice of Privacy Practices.

Patient Name (print): ____

Signature of patient or legal representative: ________________________________

Relationship to patient, if signed by legal representative________________________

Date: ____

If patient refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Present on (date and time) ____

By (name and title) ____

CONSENT TO RELEASE INFORMATION

NAME: ______________________________ DATE OF BIRTH: __________

I, the undersigned, hereby authorize Iowa Head and Neck, P.C., to release medical information concerning the above named patient to the names listed below. (For minors, per Iowa State Law, information will be given to both parents unless ordered otherwise.)

Medical information includes, but is not limited to, identification of providers of care, diagnosis, procedures, and demographic information.

Name:______________________________ Relationship:__________________

Name:______________________________ Relationship:__________________

This information relates to medical information and treatment only. We may contact you regarding any billing information.

You may leave a message on my:

Home answering machine ___NO ___YES My home number is___________

Work answering machine ___NO ___YES My work number is___________

Cell Phone ___NO ___YES My cell number is___________

I understand that I may revoke this consent at any time by sending a written notice to the office. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I do not want information released regarding:__________________________

____

Signature of patient or legal guardian Date

Relationship (if not patient)______________________________