Hearing Aid & Audiology Services

LakeENT & FPS

Ear | Nose | Throat
& facial plastic surgery

# New Patient Forms

Patient Name: ______________________ Date: ______________________

## SOCIAL HISTORY

DO YOU USE TOBACCO NOW? ____ YES ____ NO TYPE & DAILY AMOUNT ______________

HOW LONG? ______________

IN THE PAST? ____ YES ____ NO TYPE & DAILY AMOUNT______________

HOW LONG? ______________ IF STOPPED, WHEN? ______________

DO YOU USE ALCOHOLIC BEVERAGES? ____ YES ____ NO IN THE PAST? ____YES ____NO

TYPE ______________ WEEKLY AMOUNT ______________ HOW LONG?______________

## REVIEW OF SYMPTOMS:

Which of the following symptoms do you presently have?

____ FEVER
____ WEIGHT GAIN
____ WEIGHT LOSS
____ FATIGUE
____ LUMPS IN NECK
____ HEARING LOSS
____ DIZZINESS
____ EAR PAIN
____ DIFFICULTY SWALLOWING
____ HOARSENESS
____ NASAL CONGESTION
____ RUNNY NOSE
____ SORE THROAT
____ SNEEZING
____ FACIAL PRESSURE
____ HEADACHE
____ WATERY EYES
____ ITCHY EYES
____ HEARTBURN
____ ACID REFLUX
____ STOMACH PAIN
____ PALPITATIONS
____ SHORTNESS OF BREATH
____ WHEEZING
____ COUGH
____ BLOOD TRANSFUSION
____ BRUISING
____ SENSITIVITY TO HEAT OR COLD
____ SKIN LESION
____ SKIN RASH
____ WEAKNESS ARMS OR LEGS
____ NUMBNESS ARMS OR LEGS
____ SNORING
____ DAYTIME SLEEPINESS
____ WAKE UP CHOKING OR GASPING

Judith C. Milstead, MD • S. Dwight Vaught, MD • Dino Madonna, MD • J. Samuel Moak, III, MD

**Leesburg**: (352) 728-2404 | **The Villages®** • (352) 753-8448 | **Tavares** • (352) 343-7279

www.LakeENTHearing.com

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# New Patient Forms

DATE: ____________________

Name ________________________________ Date of Birth ____________ Age _____

Address (local mailing address) ____________________________________________

Permanent Address (if not resident) ________________________________________

Home # _______________ Work # _______________ Cell # _______________

Employer ______________________ Email ______________________________

Social Security Number __________ Marital Status ________ Sex: ☐ Male ☐ Female

Race _________ Preferred Language ____________ Ethnicity ___________________

Height ____________ Weight ________________

**Local Pharmacy** ________________________ Pharmacy Phone # ________________

City/State ______________________________________________________________

Emergency Contact ____________ Phone ____________ Relationship ____________

**Primary Care Physician**

Which physician requested for us to see you? ___________________________________

Do you have an Advanced Directive? ☐ Yes ☐ No

Responsible Person Information: ☐ Spouse ☐ Mother ☐ Father ☐ Guardian

Name ________________ Social Security # _______________ DOB _____________

Employer _______________________________________________

Address ________________________________________________________________

Phone: Work # ____________________ Other # _____________________________

**PATIENT INSURANCE INFORMATION**

Insurance Name ________________________ ID # ___________________________

Insured Party DOB ______________________

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## AUTHORIZATION CONSENT

I, the below named patient, parent, guardian or authorized representative of patient, hereby consent to such medical care encompassing the routine diagnostic procedures and medical treatment by my attending physician.

## LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

**I. RELEASE OF INFORMATION** - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

**II. PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

**III. MEDICARE/MEDICAID** - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

**IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE.** This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient's Name (Print) ______________________________ Date ______________________________

Signature of Patient or Legal Guardian ______________________________________________

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Patient Name: ______________________________ Date: ______________

## PAST MEDICAL HISTORY — *Which of the following conditions have you had?*

| | | |
|---|---|---|
| ____ ARTHRITIS | ____ ASTHMA | ____ ATRIAL FIBRILLATION |
| ____ GERD | ____ DIABETES | ____ EMPHYSEMA |
| ____ HEART ATTACK | ____ GLAUCOMA | ____ GOITER |
| ____ HIGH BLOOD PRESSURE | ____ HEART DISEASE | ____ HEPATITIS |
| ____ HYPERTHYROIDISM | ____ HIGH CHOLESTEROL | ____ HIV |
| ____ PNEUMONIA | ____ HYPOTHYROIDISM | ____ KIDNEY DISEASE |
| ____ TUBERCULOSIS | ____ SLEEP APNEA | ____ STROKE |
| ____ NEUROMUSCULAR | ____ COPD | ____ NEUROLOGICAL |

____ CANCER (type) ______________________________

ALLERGIES TO MEDICATIONS: ______________________________

______________________________

______________________________

PREVIOUS OPERATIONS ☐ YES ☐ NO If yes, please check or list, giving dates:

| | |
|---|---|
| ____ CANCER SURGERY OF HEAD/NECK | ____ NASAL/NOSE SURGERY |
| ____ SINUS SURGERY | ____ SKIN CANCER SURGERY |
| ____ FACIAL PLASTIC/COSMETIC SURGERY | ____ EAR SURGERY (Type) ______________ |
| ____ THYROID/PARATHYROID SURGERY | ____ HEART SURGERY (Type) ______________ |

____ OTHER SURGERIES ______________________________

______________________________

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Patient Name: ______________________________ Date: ______________

## FAMILY HISTORY

| | | | AGES OR AGES AT DEATH | PRESENT HEALTH OR CAUSE OF DEATH |
|---|---|---|---|---|
| LIVING? | ____ YES | ____ NO | ____________ | ____________ |
| FATHER | ____ YES | ____ NO | ____________ | ____________ |
| MOTHER | ____ YES | ____ NO | ____________ | ____________ |
| SPOUSE | ____ YES | ____ NO | ____________ | ____________ |
| SIBLINGS | ____ YES | ____ NO | ____________ | ____________ |
| CHILDREN | ____ YES | ____ NO | ____________ | ____________ |

PLEASE MARK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES:

____ ABNORMAL BLEEDING ____DIABETES ____ HEART DISEASE

____ STROKE ____CANCER ____HIGH BLOOD PRESSURE ____KIDNEY DISEASE

# New Patient Forms

I acknowledge and agree that Lake Ear, Nose, Throat & Facial Plastic Surgery Associates may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

_______________________________________________

Print name, relationship and phone number

_______________________________________________

Print name, relationship and phone number

_______________________________________________

Print name, relationship and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_______________________________ _______________

Signature of Patient or Authorized Representative Date

## HIPPA PRIVACY NOTICE

I have received and/or have seen and acknowledge the HIPAA PRIVACY NOTICE of Milstead, Vaught & Madonna, MD, PA. This Privacy Notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, J. Samuel Moak, III, MD, Michael Freedman, DO, Jenniffer Ferguson, PA-C, Christine Halvorsen, PA-C, Jennifer Pollard, APRN and Lacey Morgan, APRN.

Patient's Name (Print) ______________________ Date ______________________

Signature of Patient or Authorized Representative ______________________________

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# New Patient Forms

## MEDICATIONS

Today's Date: ______________________________

Patient Name: ______________________________ Date of Birth: ____________________

Pharmacy: ______________________________ Pharmacy Phone # ____________________

## LIST MEDICATIONS WITH DOSAGE YOU ARE PRESENTLY TAKING

### Including aspirin, oral contraceptives & vitamin supplements

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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