

Cochise Ear, Nose & Throat Associates, PLLC

Lawrence N. Teruel, M.D.

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**PATIENT DEMOGRAPHICS**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ Cell: \_\_\_\_\_

Patient SS# \_\_\_\_\_ Name of Parent/ Guardian if Applicable: \_\_\_\_\_

Are you the legal parent/ Guardian if applicable of the patient? YES NO Parent/ Guardian SS# \_\_\_\_\_

Employer's Name & Phone Number of Patient or Parent/ Guardian: \_\_\_\_\_

Did a Doctor refer you to this practice for Treatment? YES NO What is the Referring Doctor's Name: \_\_\_\_\_

**Patient Insurance Information**

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship to Patient: self spouse parent

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SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

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Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

**LIST ANY INDIVIDUALS THAT OUR OFFICE HAS PERMISSION TO SPEAK WITH REGARDING YOUR MEDICAL CONDITIONS:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

 **Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ 

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<u>ENT</u>	YES	NO
Hearing loss		
Ringing in ears		
Ear pain		
Ear discharge		
Runny nose		
Hard to breathe through nose		
Itchy nose		
Lump in neck		
Facial Pain		
Loss of smell		
Postnasal drip		
Snoring		
Pain with swallowing		
Dental Problems		
Nose bleeds		
Sore Throat		

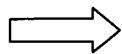
<u>Constitutional</u>	YES	NO
Fatigue		
Fever		
Weight Gain/ Loss		
<u>NEUROLOGICAL</u>		
Speech difficulties		
Migraines		
Dizziness		
Headaches		
Seizures		
Paralysis		
Tremor		
Memory Loss		
<u>EYE SYMPTOMS</u>		
Eye discomfort		
Changes in vision		
Pain		
Discharge/ Tearing		

<u>Musculoskeletal</u>	YES	NO
Muscular weakness		
Twitching		
Gait changes		
Joint pain		
Neck pain		
Arthritis		
<u>CARDIOVASCULAR</u>		
Chest pain		
Arrhythmias		
Swelling in legs/ Leg pain		
<u>ENDOCRINE</u>		
Excessive sweating		
Weight loss		
Thyroid Problems		
Hot/ Cold		
Excessive Thirst/ Hunger/Urination		

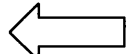
<u>Respiratory</u>	YES	NO
Shortness of Breath		
Hoarseness		
Cough		
Wheezing		
Mucous		
Coughing up blood		
<u>PSYCHIATRIC</u>		
Anxiety		
Depression		
Insomnia		
<u>GASTROINTESTINAL</u>		
Nausea/ Vomiting		
Blood in stool		
Difficulty swallowing		
Choking		
Decrease in appetite		

<u>Genitourinary</u>	YES	NO
Urgency		
Frequent Urination		
History of UTI		
Blood in urine		
Venereal Disease		
<u>INTEGUMENT (SKIN)</u>		
New skin lesions		
Lumps		
Change in Mole appearance		
Rash		
Jaundice		
<u>HEMATOLOGIC/ LYMPHATIC</u>		
Anemia		
Bleeding problems		
Easy Bruising		
Blood Disorder		

PLEASE WRITE REASON FOR VISIT: (CC)



\_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MEDICAL PROBLEMS (ILLNESSES): check all that apply**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart attack (MI)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> DVT
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> COPD/ chronic bronchitis	<input type="checkbox"/> HIV
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Cancer (please write in):	<input type="checkbox"/> <i>Other medical problems not listed:</i>	<input type="checkbox"/> Hearing Aids

**PAST SURGERIES (operations)       NO SURGICAL HISTORY**

<input type="checkbox"/> Please list previous Surgeries:	Problems with Anesthesia? YES <input type="checkbox"/> NO <input type="checkbox"/>
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**SOCIAL HISTORY: check all that apply**

<b>TOBACCO:</b> <input type="checkbox"/> Smoke <input type="checkbox"/> Chew	<input type="checkbox"/> Never	<input type="checkbox"/> Former	Year started: Year Quit:
<input type="checkbox"/> Currently smoke:	<input type="checkbox"/> less than 1 pack per day	<input type="checkbox"/> 1-2 packs/ day	<input type="checkbox"/> 3 or more packs/ day
<b>ALCOHOL USE:</b>	<input type="checkbox"/> Never	<input type="checkbox"/> often	<input type="checkbox"/> rarely
Employment:	<input type="checkbox"/> Student	<input type="checkbox"/> Employed Occupation:	<input type="checkbox"/> Not employed
<input type="checkbox"/> Caffeine Use	<input type="checkbox"/> Never	<input type="checkbox"/> how many cups/day	<input type="checkbox"/> Decaf
On a scale 1-10 where is your stress level:	Reason for stress:	Primary Language:	

**FAMILY HISTORY: check all that apply       NO FAMILY HISTORY/UNKNOWN**

	FAMILY MEMBER		FAMILY MEMBER
<input type="checkbox"/> Asthma		<input type="checkbox"/> Sinusitis	
<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Thyroid goiter	
<input type="checkbox"/> Bleeding disorder		<input type="checkbox"/> Anesthesia problems	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Meniere's disease		<input type="checkbox"/> Cancer/ what type:	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other	

**CURRENT MEDICATIONS:       NOT CURRENTLY ON ANY MEDICATIONS**

Name of Medication	Dosage (Strength)	Frequency (Times per day)

**DRUG ALLERGIES:       NO KNOWN DRUG ALLERGIES**

NAME OF DRUG (medication)	Reaction

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I understand that under the Health Insurance and Accountability Act of 1996(“HIPPA”), I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:**

**To conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).**

**To obtain payment from third party payers (insurance, etc.)**

**To conduct normal and required healthcare operations such as quality assessments and physician certifications.**

**I have been informed by Cochise Ear, Nose and Throat Associates, PLLC of their Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I have had the opportunity to review the entire Notice of Privacy Practices prior to signing this consent. I also understand that Cochise Ear, Nose and Throat Associates, PLLC has the right to change this notice from time to time and I may contact the office at any time to obtain a current copy of the Notice Of Privacy Practices.**

**I understand that I may request in writing that Cochise Ear, Nose and Throat Associates, PLLC restrict how my private information is used or disclosed to complete treatment, payment or health care operations. I also understand that Cochise Ear, Nose and Throat Associates, PLLC is not required to agree to my requested restrictions, but if they do agree then are bound to abide by such restrictions.**

**PATIENT or Guardian Name: (*Print*)** \_\_\_\_\_

**PATIENT or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**GENERAL CONSENT FOR TREATMENT**

I hereby give consent for Dr. Lawrence Teruel and his staff to perform medical care, including diagnostic procedures, medical examinations and treatment, as May in the physician's opinion is medically necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedures, treatment or examinations.

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*Patient/Guardian Signature*                      *Print Name*                                      *Date*

**ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT**

I understand and agree, whether signing as an agent or as a patient and whether insured or a member of a health insurance group, that in consideration of the services to be rendered, that I hereby individually obligate myself to pay the account of the medical facility in accordance with the regular rates, terms and interest on the unpaid balance set out by Cochise, Ear, Nose and Throat, Associates, PLLC. I understand that payment is due at the time of billing. I also understand and agree that if payment is not received in the billing office within thirty days of initial billing, that I will be charged a billing fee of \$10.00 monthly. In the event that it's necessary to place the account with a collection agency to collect the balance due, an additional 30% of the principle balance due will be added to help defray the cost of collection. Interest will accrue at a rate of 18% per annum on the principle balance. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for reasonable attorney's fees, interest and court costs. I also understand that if my account is placed with an agency for collection or placed with an attorney for legal action that a credit report will be pulled for the sole purpose of collecting the delinquent account.

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*Patient/Guardian Signature*                      *Print Name*                                      *Date*

**HEALTHCRE INSURANCE WAIVER**

I am seeking treatment for Dr. Lawrence Teruel (Cochise, Ear, Nose, and Throat Associates, PLLC) and understand that my medical insurance company may require a referral to see a specialist. I understand that I am responsible for ensuring that the referral has taken place. If I have not obtained the referral at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by y insurance.

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*Patient/Guardian Signature*                      *Print Name*                                      *Date*