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: _________________

Policy ID # _________________Group #______

Policy Holder Name: ______________________

Relationship to Patient: self spouse parent

SSN: _________________ DOB: ___________

SECONDARY INSURANCE: ______________

Policy ID # _____________ Group #___________

Policy Holder Name: _______________________

Relationship to Patient: self spouse parent

SSN: _________________ DOB: ___________

Emergency Contact: __________________ **Relationship:** __________________ **Phone #** ______________

LIST ANY INVIDUALS 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:* ____________________

ENT	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		

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

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

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

Genitourinary	YES	NO
Urgency		
Frequent Urination		
History of UTI		
Blood in urine		
Venereal Disease		
INTEGUMENT (SKIN)		
New skin lesions		
Lumps		
Change in Mole appearance		
Rash		
Jaundice		
HEMATOLOGIC/ LYMPHATIC		
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

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

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

☐ Please list previous **Surgeries**:	Problems with Anesthesia? YES ☐ NO ☐

SOCIAL HISTORY: check all that apply

TOBACCO: **☐ Smoke ☐ Chew**	**☐ Never**	**☐ Former**	**Year started:** **Year Quit:**
☐ Currently smoke:	**☐ less than 1 pack per day**	**☐ 1-2 packs/ day**	**☐ 3 or more packs/ day**
ALCOHOL USE:	**☐ Never**	**☐often**	**☐ rarely**
Employment:	**☐ Student**	**☐ Employed Occupation:**	**☐ Not employed**
☐ Caffeine Use	**☐ Never**	**☐ how many cups/day** _____	**☐ 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**
☐ Asthma		☐ Sinusitis	
☐ Hearing Loss		☐ Thyroid goiter	
☐ Bleeding disorder		☐ Anesthesia problems	
☐ Stroke		☐ Heart disease	
☐ Meniere's disease		☐ Cancer/ what type:	
☐ Diabetes		☐ 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*