

PATIENT INFORMATION SHEET

**ALAMANCE EAR, NOSE AND THROAT, LLP
DR. WILLIAM VAUGHT, DR. PAUL JUENGEL, DR. P. SCOTT BENNETT
DR. CHAPMAN McQUEEN, DR. J. MADISON CLARK**

REFERRED BY: _____

PATIENT'S NAME _____ AGE ____ DOB _____ SEX ____ (M) ____ (F)

MAILING ADDRESS _____ PHONE (____) _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: S ____ M ____ W ____ D ____ SEP ____ SOCIAL SECURITY #: _____

PATIENT'S EMPLOYER (IF APPLICABLE) _____

DEPARTMENT: _____ DEPT/EXT _____

WORK ADDRESS _____ PHONE (____) _____

IF BILLING ADDRESS IS DIFFERENT THAN PATIENT'S MAILING ADDRESS, PLEASE COMPLETE

NAME: _____ ADDRESS: _____ PHONE (____) _____

IF PATIENT IS MARRIED OR IS A DEPENDENT CHILD, COMPLETE ITEMS BELOW

FULL NAME OF SPOUSE OR PARENT: _____ DATE OF BIRTH _____

EMPLOYER NAME AND ADDRESS: _____

BUSINESS PHONE (____) _____ SOCIAL SECURITY NUMBER: _____

HEALTH INSURANCE INFORMATION

NAME AND ADDRESS OF INSURANCE COMPANY: _____

NAME OF INSURED: _____ DATE OF BIRTH _____

POLICY NUMBER: _____ GROUP NUMBER: _____

MEDICARE NUMBER: _____ MEDICAID NUMBER: _____

DO YOU HAVE OTHER INSURANCE: ____ YES ____ NO

PLEASE ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARDS.

SIGNATURE: _____ DATE: _____

(Patient, Parent or Guardian, if patient is minor)

(PLEASE ALSO COMPLETE BACK OF THIS PAGE)

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. CO-PAYS ARE DUE **BEFORE** SERVICES ARE RENDERED.

METHOD OF PAYMENT: CASH_____ CHECK_____ BANKCARD_____

WHO WILL BE RESPONSIBLE FOR THE PATIENT'S MEDICAL EXPENSES? _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

NAME: _____ PHONE (____) _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO ALAMANCE EAR, NOSE AND THROAT, LLP. I hereby authorize the physician designated to release information acquired in the course of my examination and treatment. I, also, authorize you to give me reasonable and proper medical care by today's standards and hereby assign payment directly to the designated physician for any medical / surgical procedures performed. This signature is valid until rescinded in writing at a later date. Also, I understand that I am responsible for any amount not covered by my insurance. If my account should become delinquent, I agree to pay for any expenses including attorney's fees and court costs.

If you are seen without the proper referral or prior authorization from your primary care physician, you will be responsible for the charges for that visit.

Family members, guardian and/or authorized person(s) who may have access to your personal health information.

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE: _____ DATE _____

(Patient, Parent or Guardian, if patient is minor)



ALAMANCE ENT & FACIAL PLASTICS

WILLIAM W. VAUGHT, MD PAUL H. JUENGEL, MD

CHAPMAN T. MCQUEEN, MD

J. MADISON CLARK, MD P. SCOTT BENNETT, MD

For Office Use Only

Patient Name: _____

MR#: _____ **Sex:** M F

Date of Birth: _____ **Age:** _____

Date of Visit: _____

WHO IS YOUR REGULAR PHYSICIAN? _____ **WHO REFERRED YOU HERE?** _____

WHAT IS THE MAIN PROBLEM OR SYMPTOM THAT BRINGS YOU HERE? _____

PAST MEDICAL HISTORY AND FAMILY HISTORY

PLEASE CIRCLE YES (Y) OR NO (N) FOR YOURSELF AND FAMILY. USE EXTRA SPACE BESIDE ANSWER, IF NEEDED, TO EXPLAIN, OR TO INDICATE WHICH FAMILY MEMBERS ARE AFFECTED.

Disease	Yourself	Family	Who is affected?	Drug Allergies and type of reaction:
Alcoholism	Y N	Y N		
Anemia	Y N	Y N		
Arthritis	Y N	Y N		
Asthma	Y N	Y N		
Bleeds Easily	Y N	Y N		
Cancer (type)	Y N	Y N		
Diabetes	Y N	Y N		Medications and doses:
Epilepsy	Y N	Y N		
Glaucoma	Y N	Y N		
Heart Disease	Y N	Y N		
Hepatitis	Y N	Y N		
HIV or AIDS	Y N	Y N		
High Cholesterol	Y N	Y N		
High Blood Pressure	Y N	Y N		
Kidney Disease	Y N	Y N		
Mental Illness	Y N	Y N		
Obesity	Y N	Y N		
Osteoporosis	Y N	Y N		
Stomach Ulcers	Y N	Y N		
Stroke	Y N	Y N		
Sexually Transmitted Disease (please specify)	Y N	Y N		
Thyroid Disease	Y N	Y N		
Tuberculosis	Y N	Y N		

Other Medical History: _____

Past Surgeries: _____

Prior Allergy Testing: _____

PATIENTS: PLEASE CONTINUE ON BACK OF PAGE

Social History: Occupation: _____ Marital Status: _____ Children: _____
 Current Smoker: Y N Past Smoker: Y N Date Quit: _____ Packs per day: _____ Years Smoked: _____
 Snuff/Chewing Tobacco: _____ Other Recreational Drug Use: _____
 Alcohol Use: Y N Number of Drinks Per Day of Beer: _____ Wine: _____ Liquor: _____

If patient is a child:

Are there smokers in the household? Y N
 Where does the child stay during the day? ___ At Home ___ In preschool/ daycare ___ School Other: _____

Review of Systems: Are you currently having any of the following

Dizziness:	Y N	Weight Change:	Y N	Joint Pain:	Y N
Hearing Change:	Y N	Anxiety:	Y N	Headache:	Y N
Ringing in Ears:	Y N	Depression:	Y N	Urinary problems:	Y N
Fever:	Y N	Night Sweats:	Y N	Difficulty Swallowing:	Y N
Rash:	Y N	Cough:	Y N	Shortness of Breath:	Y N
Chest Pain:	Y N	Heartburn/ Indigestion:	Y N	Vision Change:	Y N
Nausea/Vomiting:	Y N	Easy Bleeding:	Y N		
Weakness/ Numbness in arms/legs:	Y N	Heat/Cold intolerance:	Y N		

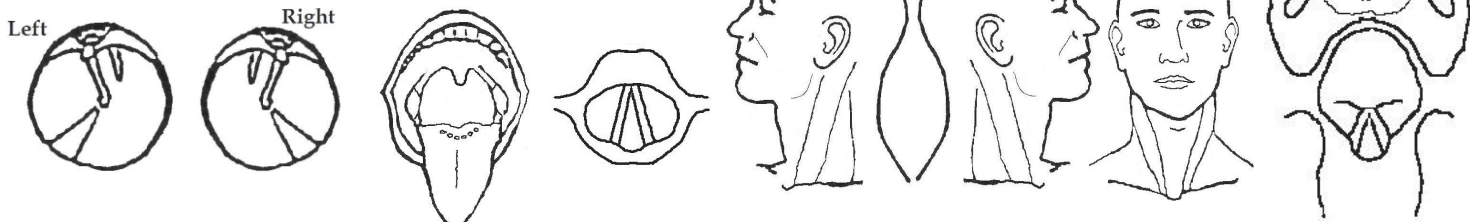
If any of the above symptoms are not directly related to the problem for which we are now seeing you, you are encouraged to follow up with your primary care physician for further evaluation.

*******DO NOT WRITE BELOW. FOR PHYSICIAN USE ONLY.*******

Physical Exam: Vital Signs: Ht _____ Wt _____ Pulse _____ BP _____ / _____ Temp _____

Normal **Abnormal** (if marked abnormal, findings are dictated)

_____ _____ General: Well-developed, Well-nourished in no acute distress
 _____ _____ Vocal Quality: no hoarseness or stridor
 _____ _____ Head/Face: NCAT. Symmetric facial features. No significant skin lesions or scars
 _____ _____ Face: no tenderness with sinus percussion
 _____ _____ Facial Strength normal and symmetric
 _____ _____ External Ears without lesions or deformity. Ear canals free of cerumen or infection. Tympanic membranes intact with no infection, good landmarks and normal light reflex. Normal mobility by pneumatic otoscopy.
 _____ _____ Weber and Rinne exams normal. Grossly normal hearing.
 _____ _____ External Nose dorsum essentially midline with no skin lesions
 _____ _____ Nasal Septum essentially straight. Mucosa without congestion or Erythema. Turbinates normal. No polyps.
 _____ _____ Lips and gums without lesions. No dental caries.
 _____ _____ Oropharynx: Tongue, floor of mouth and buccal mucosa without lesions. Palate and uvula without lesions. No tonsillar hypertrophy or exudates. Posterior pharynx without lesions or exudates.
 _____ _____ Larynx: tongue base, epiglottis, vocal cords without lesions, Erythema or exudates. Normal vocal cord motion
 _____ _____ Hypopharynx/Piriform Sinuses: Clear, no pooling of secretions or visible lesions.
 _____ _____ Nasopharynx free of visible lesions by indirect exam.
 _____ _____ UNABLE TO EXAMINE LARYNX, HYPOPHARYNX OR NASOPHARYNX DUE TO GAG REFLEX
 _____ _____ Neck Supple, symmetric without masses or skin lesions. Trachea midline.
 _____ _____ Thyroid symmetric without palpable masses or nodules or tenderness. No thyromegaly.
 _____ _____ Parotid and submandibular glands are symmetric with no tenderness or masses or palpable stones.
 _____ _____ Cervical lymph nodes are without palpable lymphadenopathy or tenderness.
 _____ _____ Lungs clear to Auscultation. No wheezes, rales or rhonchi.
 _____ _____ Heart: Regular Rate and Rhythm without murmurs
 _____ _____ Cranial Nerves II-XII grossly intact.
 _____ _____ Eyes: Gaze and Ocular Motility are normal.



Assessment: _____

Plan: _____

___ New Pt ___ Consult ___ Est Pt Level: 1 2 3 4 5 Physician Signature: _____

HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action of proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want that restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any charges. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____