Hoover
Ear, Nose and Throat
Associates, P.C.
2116 Data Park
Hoover, AL 35244
205-733-9595
205-733-9599 Fax

Hoover Hearing Clinic
A division of
Hoover ENT Associates, P.C.
2116 Data Park
Hoover, Alabama 35244
205-733-9694 Tel
205-733-9599 Fax

ACCOUNT #	DATE	MD	NEW	UPDATE

PATIENT INFORMATION

Patient's Full Name ______________________________ DOB ____________ Age__________

Patient's SSN __________________ Sex: Male____ Female____ Preferred Language____________

Place of Birth: City ______________________________ State _______ Country __________

Marital Status: Single_____ Married_____ Widowed _____ Divorced _____ Separated ________ Student: Yes / No

Race: Cauc _____ Afr American _____ Asian _____ Other _____ Ethnicity: Hispanic _____ Non-Hispanic ______

Address __________________________ City/State ____________________ Zip __________

Home Phone _____________ Mobile ________________ Email ______________________

Employer ____________________ Occupation ______________ Work Phone ____________

Spouse ___________________________ Spouse DOB__________ Spouse Phone ____________

Spouse's Employer ____________________________________ Work Phone ____________

In the case of emergency, contact: Name ____

Relationship: __________________ Phone ________________

If Patient is a MINOR, please complete the following:

Responsible Party Name ________________________________ Relationship _____________

Address __________________________ City/State ____________________ Zip __________

Mother's Name ________________________________ Employer ____________________

Mother's DOB __________________ SSN __________________ Work Phone _____________

Father's Name _________________________________ Employer ____________________

Father's DOB ___________________ SSN __________________ Work Phone _____________

INSURANCE INFORMATION (***If name on card is different from responsible party, DOB is required***)

Primary Insurance ____________________ Contract # ______________ Group # __________

Name of Insured ____________________________________ ***DOB** _________________

Secondary Insurance __________________ Contract # ______________ Group # __________

Name of Insured ____________________________________ ***DOB** _________________

NOTE: Adult bringing child for treatment is responsible for payment of account. If 18 or older, you are responsible for incurred charges. If patient is a student, parent/responsible party signature is required.

Revised 8/31/2018

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Authorization to Disclose Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (PHI).

I wish to be contacted in the following manner (Please check all that apply and provide the phone number(s) or email below):

Home#________________________________ Work#________________________________

Cell#________________________________

Okay to leave message with detailed information __Home __Work __Cell

Leave message with call back number only __Home __Work __Cell

I prefer to be contacted regarding appointment reminders in the following manner:

Home #___ Cell #___

My protected health information may be released to the following individuals:

Name:____________________ Relationship:__________________ Phone:_________________

Name:____________________ Relationship:__________________ Phone:_________________

Name:____________________ Relationship:__________________ Phone:_________________

Name:____________________ Relationship:__________________ Phone:_________________

I, the undersigned, understand that I have the right to change the above information at any time by completing another form.

____ _________________________

Patient or Parent's/Guardian's Signature Date

____ _________________________

Print name Birth Date

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Name:____ Date of Birth:__________________________ Check one: ☐ Male ☐ Female

In order to ensure adequate medical care, the following is very important. Thank you for completing this form!

If you need additional space (e.g. for medications or allergies), please ask the receptionist for additional pages.

Who is your primary care physician (PCP)?	**Who is the doctor who referred you to Hoover ENT?**
PCP's Name:	Doctor's Name:
PCP's Address:	Doctor's Specialty:
	Doctor's Fax #:
PCP's Fax #:	What pharmacy do you prefer to use?
Would you like us to send your primary care physician clinical notes concerning today's visit? ☐ Yes ☐ No	Pharmacy Street, City and Phone:

What is the **MAIN MEDICAL REASON FOR YOUR VISIT** to Hoover ENT? ____

In the box below, please list all **OPERATIONS OR MAJOR MEDICAL PROCEDURES** that you have had in the past.

(*Examples: tonsillectomy, heart surgery or stent, knee arthroscopy, etc.)*

Procedure	**Year Performed**

In the box below, please list any and all **ADDITIONAL MEDICAL PROBLEMS** that you have had in the past.

Please include: Problems that have caused you to be hospitalized
Problems for which you see a doctor on a regular basis
Problems for which you take regular medication

Diagnosis	**Approximate Year it Started**

Please list all **MEDICATIONS** that you take regularly (prescription, over-the-counter, herbal, other):

Drug Name	**Dosage / Amount**	**How Often**	**Reason you take this medication**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
Do you take a daily aspirin tablet? ☐ Yes ☐ No			

Name: ______________________________ Date of Birth: ______________________

Please list all **ALLERGIES** that you have to any medications, foods, or other substances, or check ☐ none known:

Substance (medication, food, latex, etc)	What was the adverse reaction?	Was it severe or mild?
1)		
2)		
3)		
4)		

FAMILY HISTORY: If any immediate family have any of the following, please check the box and write which relative has this diagnosis (e.g. mother, son, sister, etc).

☐ Diabetes ______	☐ Asthma ______	☐ Chronic ear disease ______
☐ High blood pressure ______	☐ Allergies ______	☐ Early hearing loss ______
☐ Stroke ______	☐ Chronic sinus infections ______	☐ Bleeding disorders ______
☐ Heart attack ______	☐ Heart failure ______	☐ Problem with anesthesia ______
☐ Other (please list):		☐ Cancer (list type): ______

SOCIAL HISTORY: (Check the box or fill in numbers where applicable)

Alcohol Use: ☐ Daily ☐ Weekly or monthly ☐ Only a few times a year ☐ Never

Tobacco Use: ☐ Use now ☐ Quit (if quit, what year did you quit?______) ☐ Never used

If you use tobacco products now, please complete the following:

Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip/chew ☐ Vape

Number per day:______ Number of years of tobacco use: ______

Type of Occupation: ______ **Retired?** ☐ Yes ☐ No **Disabled?** ☐ Yes ☐ No

REVIEW OF SYSTEMS: (Please check all of the following that you have had ***in the last six months***)

Constitutional	Ears, Nose & Throat	Gastrointestinal	Psychiatric
☐ Frequent fatigue	☐ Hearing loss	☐ Heartburn or reflux	☐ Memory loss or confusion
☐ Frequent fever	☐ Ringing / other sound in ears	☐ Painful or difficult swallowing	☐ Trouble sleeping
☐ Unexplained weight loss	☐ Ear pain	☐ Food catching in throat	☐ Anxiety
Allergic / Immune	☐ Nasal obstruction	☐ Chronic abdominal pain	☐ Depression or mania
☐ Hives (urticaria) or itching	☐ Non-healing sore in mouth or throat	**Genitourinary**	**Skin / Integument**
☐ Prone to frequent infections		☐ Painful or difficult urination	☐ Unexplained rash
Eyes	☐ New palpable lump in neck	☐ Frequent or uncontrolled urination	☐ Worrisome skin mass
☐ Itchy, red or watery eyes	**Cadiovascular**		**Hematologic/Lymphatic**
☐ New vision loss / double vision	☐ Chest pain (angina)	**Musculoskeletal**	☐ Anemia
☐ Dry eyes	☐ Irregular heartbeat	☐ Joint pain or arthritis	☐ Easy bleeding or bruising
☐ Glaucoma	**Pulmonary**	☐ Unexplained muscle weakness	☐ Enlarged glands or lymph nodes
☐ Cataracts (cloudy lens in eye)	☐ Frequent cough	**Neurologic**	**Endocrine**
	☐ Shortness of breath	☐ Frequent headaches	☐ Diabetes or high blood sugar
	☐ Wheezing	☐ Numbness or tingling	☐ Thyroid disease
	☐ Snoring	☐ Seizures	
		☐ Loss of coordination	**Other:**
		☐ Slurred speech	

Name: ______________________________ Date of Birth: ______________________________

Please complete this page only if you require additional space.

Please list any ***additional*** **MEDICATIONS** that you take regularly (prescription, over-the-counter, herbal, other):

Drug Name	Dosage / Amount	How Often	Reason you take this medication:
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
Others:			

Please list any ***additional*** **ALLERGIES** that you have to any medications, foods, or other substances:

Substance (medication, food, latex, etc)	What was the adverse reaction?	Was it severe or mild?
5)		
6)		
7)		
8)		

Is there ***any additional information*** regarding your health of which you would specifically like to make us aware?

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CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment necessary for the care of the patient named below. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, and those involved in the payment of the patient's account. I further acknowledge full financial responsibility for any services rendered by Hoover Ear, Nose and Throat Associates, P.C. ("Hoover ENT") and/or Hoover Hearing Clinic (*a division of Hoover ENT Associates, P.C.*), and understand that payment of charges incurred in the office are due at the time of service. I also understand that charges not covered by insurance remain my responsibility, and I assign insurance benefits to Hoover ENT and/or Hoover Hearing Clinic. In the event an account is more than 90 days past due, I agree to pay all costs of collection including collection fees, attorney's fees and hereby waive all rights of exemption under the Constitution of the State of Alabama.

PRESCRIPTION REFILLS, MESSAGES, AND AFTER-HOUR CALLS

I understand that prescriptions from other physicians will not be refilled by Hoover ENT. If I have not seen a Hoover ENT physician within one year, no refills will be given. Unless there is a true emergency, no messages will be answered after 3:30 p.m. Dr. Boyd does not have after-hours call availability. If I have a true medical emergency, I understand that I am to dial the emergency 911 operator. No calls for Hoover Hearing Clinic will be answered or messages returned after 4:30 pm. Hoover Hearing Clinic does not have after-hours call availability.

In order to provide accurate and excellent medical care, I understand that Hoover ENT utilizes software that can obtain some information regarding past medications I have been prescribed or taken. I understand this information is obtained from the pharmacies I have used and a prescription clearing house service used by the pharmacies. This information will be used in facilitating my medical care and will be considered protected health information just like all of the other health information I provide to Hoover ENT. I agree to allow Hoover ENT to obtain this information electronically.

FEES FOR MISSED APPOINTMENTS AND REQUESTS FOR MEDICAL RECORDS

There will be a $25 fee if you do not cancel your appointment at least 24 hours prior to your scheduled appointment time. There will be a $25 fee for rescheduling surgery from the original surgery date. There will be a fee for copying medical records according to the number of pages copied in addition to the cost for postage.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices for Hoover ENT Associates, P.C. and/or Hoover Hearing Clinic. A copy of the Notice can be found on the websites (*www.hooverent.com*, *www.hooverhearingclinic.com*).

BY SIGNING I ACKNOWLEDGE AND AGREE TO THE ABOVE INFORMATION

________________________________ ______________________
Signature of Patient | Date

________________________________ ______________________
Printed Name of Patient | Date of Birth

________________________________ ________________________________
Printed Name of Parent/Patient's Representative (if applicable) | Signature of Parent/Patient's Representative (if applicable)