Coastal Ear, Nose & Throat Surgeons

984 First Colonial Road, Suite 302
Virginia Beach, VA 23454
(757)481-0385 Fax: (757)481-6946

Date: _____ Chart #: _____

Patient's Name: _____

Address: _____
(Street) (City) (State) (Zip)

Age: _____ Date of Birth: _____ Marital Status: M W D S

Home Phone #: _____ Cell Phone #: _____

Male: _____ Female: _____ Allergic To: _____

S.S.N: _____

Everyone Please Fill Out the Next Section:

If patient is a child, information pertains to the parent. If patient is an adult, information pertains to you.

Name of Insurance Policy Holder: _____ Policy Holder S.S.N : _____

Address if Different than Above: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Work Phone #: _____ Date of Birth: _____
(If Different From Above)

Name of Spouse: _____

Occupation: _____ Spouse's Employer: _____

Spouse's Employer's Address: _____

Spouse's Date of Birth: _____ Spouse's S.S.N: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Referring Doctor: _____

Family Physician: _____

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INITIAL HISTORY

Name: _____ Age: _____ Date: _____

Reason for Visit: _____ Duration: _____
(Please be Specific)

PLEASE CHECK ALL THAT APPLY TO YOU

EAR PROBLEMS

_____ Hearing Loss: Gradual _____ Sudden _____
_____ Ear Infections: Number per Year _____
_____ Ear Noises
_____ Dizziness/Vertigo
_____ Difficulty Understanding
_____ Noise Exposure

_____
(Type e.g. guns)

_____ Hearing Aid: Right Ear _____
Left Ear _____
_____ Family History of Hearing Loss

NOSE PROBLEMS

_____ Stuffiness/Blockage
_____ Runny Nose
_____ Post Nasal Drip
_____ Sneezing
_____ Nose Bleeds
_____ Snoring
_____ Hay Fever

THROAT PROBLEMS

_____ Sore Throats: Number per Year _____
_____ Trouble Swallowing
_____ Swollen Glands
_____ Hoarseness
_____ Mouth Breathing
_____ Cough/Spitting up Blood

PERSONAL HISTORY

_____ Smoke: Amount _____
_____ Drink: Amount _____

Occupation: _____

Referring Physician: _____

PAST HISTORY

_____ Glaucoma
_____ Seizures
_____ Arthritis
_____ Asthma
_____ Ulcers
_____ Acid Reflux
_____ Hepatitis
_____ Liver Disease
_____ Diabetes
_____ Hypoglycemia
_____ Thyroid
_____ High Blood Pressure
_____ Heart Attack
_____ Chest Pain
_____ Heart Failure
_____ Stroke
_____ Mitral Valve Prolapse
_____ Palpitations
_____ Rheumatic Fever
_____ Kidney/Bladder
_____ Prostate
_____ Migraine

PREVIOUS SURGERY:

Type and Date: _____

_____

MEDICATIONS NOW TAKING: Including over-the-counter medications and aspirin

Type and Dose: _____

_____

DRUG ALLERGIES

Type: _____

_____

FAMILY HISTORY:

_____ Heart Disease/Blood Pressure
_____ Anesthesia Problems
_____ Bleeding Disorders
_____ Muscular Dystrophy
_____ Allergy
_____ Cancer
Other: _____

Mother: Alive___ Deceased___ Cause_____
Father: Alive___ Deceased___ Cause_____

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Patient Name: _____ Date: _____

Consent to Treatment: I agree to be treated by Coastal Ear, Nose & Throat Surgeons and/or Virginia Beach Hearing Center. Any other treatment to include testing, minor surgical procedures and such other office procedures as the physician deems necessary with further consent from patient.

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____

Release of Information: I authorize the release of medical information to my insurance company and referring physician including diagnosis and any record of treatment and examination rendered to me and also request that any benefits due on my behalf be paid directly to Coastal Ear, Nose & Throat Surgeons in the office setting, the hospital setting, the emergency room Ambulatory Surgery Center or Operating Room.

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____

Agreement to be financially Responsible: I/We _____ agree to be financially responsible for the cost of all medical services rendered to the patient by Coastal Ear, Nose & Throat Surgeons. If payment for these services is not made when requested, I agree to pay, in addition to the physician's fees, all cost of collecting the amount due, which costs to include interest and collection/attorney's fees equal to 33.3% of the amount due and all court costs expended in the collection of this medical bill. I understand that my insurance will be filed for me as a courtesy and that I will be responsible for payment of any amount not paid by the insurance company because of deductible, co-insurance, lapse of coverage or cancellation of coverage.

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____

Please note that we do file insurance for everyone as a courtesy. There are certain companies with whom we participate and you will only be asked to pay your co-pay or cost share on the date of the visit. However, if you have insurance coverage with a company with whom we do not participate, you will be asked to pay for the cost of the visit on the day of service. We will file your insurance claim for you so that you can receive your reimbursement. We will also file for the cost of any testing and/or surgery done in the office, but if your insurance company has not paid in 30 days, you will become responsible for the bill. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. We have no control over what YOUR insurance company pays

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PRIVACY PRACTICES AKNOWLEDGEMENT

I am familiar with the Privacy Practices of the facility and have been provided an opportunity to review them.

Patients Name: _____ Birth Date: _____

Signature: _____ Today's Date: _____

I authorize the following people to discuss my medical and financial information with the physicians and staff of Coastal Ear, Nose & Throat Surgeons.

Name	Relationship	Date of Birth

Due to our continued efforts to keep your records private; this sheet and the Privacy Practices must be reviewed and signed for every year.

Signature and Date	