

Iowa Head and Neck, PC

PATIENT INFORMATION

Patient #:	Date of Birth:
Name:	Social Security #:
Address:	Sex:
City:	Marital Status:
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Effective date:	Effective date:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber Birthdate:	Subscriber Birthdate:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to Iowa Head and Neck, PC when assignment is accepted

Authorization To Release Medical Information. I hereby authorize Iowa Head and Neck, PC to release any information necessary for my course of treatment.

Signed (patient or parent if minor)

Date

NAME: _____ AGE: _____ DATE: _____

WHO SENT YOU TO SEE DOCTOR: _____

REASON FOR SEEING DOCTOR: _____

Since this problem started, have you had any of the following? (Please answer all questions by circling Yes or No)

Weight loss (Amount lbs. since)	Yes	No	Neck pain	Yes	No
Weight gain (Amount lbs. since)	Yes	No	Heartburn	Yes	No
Fever	Yes	No	Nausea or vomiting	Yes	No
Allergy Symptoms: Sneezing, Watery eyes, Runny nose	Yes	No	Swelling of lymph nodes	Yes	No
Ear pain	Yes	No	Frequent urination	Yes	No
Ringling in one or both ears	Yes	No	Dizziness / Lightheadness	Yes	No
Loss of hearing	Yes	No	Headaches	Yes	No
Change in taste or smell	Yes	No	Blurred Vision or Double Vision	Yes	No
Change in voice or hoarseness	Yes	No	Stiffness, pain, or swelling of joints	Yes	No
Shortness of breath / Difficulty breathing	Yes	No	Skin rash or other skin problems	Yes	No
Cough	Yes	No			

YOUR PAST MEDICAL HISTORY:

**ALLERGIES TO MEDICATIONS: No Yes What? _____

CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER MEDICATIONS):

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

SURGERIES, HOSPITALIZATIONS AND APPROXIMATE DATES:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____
- 7. _____ 8. _____ 9. _____

BROKEN BONES / INJURIES: _____

HAS ANYONE EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING: (CIRCLE YES OR NO)

DIABETES	YES	NO	MITRAL VALVE PROLAPSE	YES	NO
HEART DISEASE	YES	NO	STOMACH ULCERS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	LUNG DISEASE	YES	NO
STROKE	YES	NO	HIATAL HERNIA	YES	NO
THYROID DISEASE	YES	NO	CANCER	YES	NO
ASTHMA	YES	NO	SLEEP APNEA	YES	NO

OTHER SERIOUS HEALTH PROBLEMS (PLEASE LIST): _____

SOCIAL HISTORY:

Habits (Past or Currently) (Circle Yes or No)
 Tobacco Yes No Duration, Type used, and Amount _____
 Alcohol Yes No Duration, Type used, and Amount _____
 Coffee/Caffeine Yes No Amount _____
 Illegal Drugs Use (Marijuana, cocaine, meth, other) YES NO Duration, Type Used, and Amount _____

IS THERE A HISTORY OF CANCER OF THE HEAD OR NECK IN YOUR PARENTS OR GRANDPARENTS? YES NO

SIGNATURE OF PATIENT OR INDIVIDUAL COMPLETING FORM: _____

NAME: _____ DATE: _____

HPI _____

Location, Quality, Severity, Duration, Timing, Context, Mod. Factors, Associated signs/symptoms BRIEF 1-3 EXT 4 OR >

GENERAL APPEARANCE

Intake Person _____

HEAD AND FACE

EARS:

External Aud Canals (Rt/Lt)

Tympanic Membranes (Rt/Lt)

TUNING FORKS (Rt/Lt)

EXTERNAL EARS AND NOSE

NASAL MUCOSA/SEPTUM/TURBINATE

LIPS/TEETH/GUMS

**OROPHARYNX, ORAL MUCOSA, HARD/SOFT PALATES,
TONGUE, TONSILS, AND POSTERIOR PHARYNX**

PHARYNGEAL WALLS/PYRIFORM SINUSES

MIRROR EXAM-LARYNX/HYPOPHARYNX

MIRROR EXAM-NASOPHARYNX

**NECK
THYROID
RESPIRATORY**

Audiometry
Tympanometry
Sinus Xray

IMPRESSION

RECOMMENDATION

Letter Dictated
DR

These are the findings of my physical examination of this patient. I have reviewed the written history provided on the opposite side of this page. _____

CONSENT TO RELEASE INFORMATION

NAME: _____ DATE OF BIRTH: _____

I, the undersigned, hereby authorize Iowa Head and Neck, P.C., to release medical information concerning the above named patient to the names listed below. (For minors, per Iowa State Law, information will be given to both parents unless ordered otherwise.)

Medical information includes, but is not limited to, identification of providers of care, diagnosis, procedures, and demographic information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This information relates to medical information and treatment only. We may contact you regarding any billing information.

You may leave a message on my:

Home answering machine NO YES My home number is _____

Work answering machine NO YES My work number is _____

Cell Phone NO YES My cell number is _____

I understand that I may revoke this consent at any time by sending a written notice to the office. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I do not want information released regarding: _____

X _____
Signature of patient or legal guardian Date

Relationship (if not patient) _____


IOWA HEAD AND NECK, P.C.

Acknowledgement of Notification of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Iowa Head and Neck, P.C., Notice of Privacy Practices. Iowa Head and Neck, P.C. is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Brochure of full HIPAA Privacy Act is available in the waiting room.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I may request a copy of the Notice of Privacy Practices.

Patient Name (print): _____

Signature of patient or legal representative:  _____

Relationship to patient, if signed by legal representative _____

Date: _____

If patient refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Present on (date and time) _____

By (name and title) _____