Patient Name:_____Date:_____

SOCIAL HISTORY

DO YOU USE TOBACCO NOW? __ YES __ NO TYPE & DAILY AMOUNT _____

HOW LONG? _____

IN THE PAST? __ YES __ NO TYPE & DAILY AMOUNT _____

HOW LONG?_____ IF STOPPED, WHEN?

DO YOU USE ALCOHOLIC BEVERAGES? __ YES __ NO IN THE PAST? __ YES __ NO

TYPE _____ WEEKLY AMOUNT _____ HOW LONG?_____

REVIEW OF SYSTEMS:

Which of the following symptoms do you presently have?

__ FEVER
__ WEIGHT GAIN
__ WEIGHT LOSS
__ FATIGUE
__ LUMPS IN NECK
__ HEARING LOSS
__ DIZZINESS
__ EAR PAIN
__ DIFFICULTY SWALLOWING
__ HOARSENESS
__ NASAL CONGESTION
__ RUNNY NOSE
__ SORE THROAT
__ SNEEZING
__ FACIAL PRESSURE
__ HEADACHE
__ WATERY EYES
__ ITCHY EYES

__ HEARTBURN
__ ACID REFLUX
__ STOMACH PAIN
__ PALPITATIONS
__ SHORTNESS OF BREATH
__ WHEEZING
__ COUGH
__ BLOOD TRANSFUSION
__ BRUISING
__ SENSITIVITY TO HEAT OR COLD
__ SKIN LESION
__ SKIN RASH
__ WEAKNESS ARMS OR LEGS
__ NUMBNESS ARMS OR LEGS
__ SNORING
__ DAYTIME SLEEPINESS
__ WAKE UP CHOKING OR GASPING

Lake Ear, Nose, Throat & Facial Plastic Surgery Associates

DATE: _____

NAME: _____Date of birth: _____Age: _____
Last First Middle

ADDRESS (Local Mailing Address): _____

_____

ADDRESS (Permanent (If not resident): _____

Home # _____ Work # _____ Cell # _____

Employer_____Email: _____

Social Security Number: _____ Marital Status: _____ Sex: ❒ Male ❒ Female

Race_____Preferred Language_____Ethnicity_____

Height _____ Weight _____

Local Pharmacy: _____ **Pharmacy Phone # _____**

City/State: _____

Emergency Contact: _____Phone: _____Relationship:_____

Primary Care Physician_____

Which physician requested for us to see you? _____

Do you have an Advanced Directive? [ ] Yes [ ] No

Responsible Person Information: ❒ Spouse ❒ Mother ❒ Father ❒ Guardian

Name _____ Social Security # _____ DOB _____

Employer _____

Address _____

Phone: Work # _____ Other # _____

PATIENT INSURANCE INFORMATION

Insurance Name _____ ID # _____

Insured Party DOB _____

Lake Ear, Nose, Throat & Facial Plastic Surgery Associates
601 E Dixie Ave. Plaza 901 Leesburg, FL 34748 - (352) 728-2404
1501 US 441 N Suite 1402 The Villages, FL 32159 - (352) 753-8448
1819 Salk Ave Tavares, FL 32778 - (352) 343-7279

AUTHORIZATION CONSENT

I, the below named patient, parent, guardian or authorized representative of patient, hereby consent to such medical care encompassing the routine diagnostic procedures and medical treatment by my attending physician.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT'S AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient's Name (print): _____Date:_____

Signature of Patient or Legal Guardian: _____

Patient Name:_____**Date:**_____

PAST MEDICAL HISTORY---<u>Which of the following conditions have you had?</u>

__ ARTHRITIS	__ASTHMA	__ ATRIAL FIBRILLATION
__ GERD	__ DIABETES	__ EMPHYSEMA
__ HEART ATTACK	__ GLAUCOMA	__ GOITER
__ HIGH BLOOD PRESSURE	__ HEART DISEASE	__ HEPATITIS
__ HYPERTHYROIDISM	__ HIGH CHOLESTEROL	__ HIV
__ PNEUMONIA	__ HYPOTHYROIDISM	__KIDNEY DISEASE
__ TUBERCULOSIS	__ SLEEP APNEA	__ STROKE
__NEUROMUSCULAR	__ COPD	__ NEUROLOGICAL

__ CANCER (Type)_____

<u>ALLERGIES TO MEDICATIONS</u>: _____

_____

_____

PREVIOUS OPERATIONS: _____YES? _____ NO? If yes, please check or list, giving dates:

__ CANCER SURGERY OF HEAD/NECK	__ NASAL/NOSE SURGERY
__ SINUS SURGERY	__ SKIN CANCER SURGERY
__ FACIAL PLASTIC/COSMETIC SURGERY	__ EAR SURGERY (Type)_____
__ THYROID/PARATHYROID SURGERY	__ HEART SURGERY (Type)_____

__ **OTHER SURGERIES** _____

_____

<u>FAMILY HISTORY</u>		**AGES OR**	**PRESENT HEALTH**
Living? YES/NO		**AGES @ DEATH**	**OR CAUSE OF DEATH**
FATHER	__ YES __ NO	_____	_____
MOTHER	__ YES __ NO	_____	_____
SPOUSE	__ YES __ NO	_____	_____
SIBLINGS	__ YES __ NO	_____	_____
CHILDREN	__ YES __ NO	_____	_____

<u>Please mark illnesses which have occurred in any of your blood relatives:</u>

__ Abnormal bleeding __ Diabetes __ Heart Disease __Stroke

__ Cancer __High Blood Pressure __ Kidney Disease

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I acknowledge and agree that Lake Ear, Nose, Throat & Facial Plastic Surgery Associates may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

_____
Print name, relationship, and phone number

_____
Print name, relationship, and phone number

_____
Print name, relationship, and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____ Date: _____
Signature of Patient or Authorized Representative

HIPAA PRIVACY NOTICE

I have received and/or have seen and acknowledge the HIPAA PRIVACY NOTICE of Milstead, Vaught & Madonna, MD, PA. This Privacy Notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, Michael Freedman, DO, Jenniffer Ferguson, PA-C and Christine Halvorsen, PA-C.

Name of patient (print): _____Date_____

Signature of patient or authorized representative: _____

Todays Date:
Patient Name: **Date of Birth:**
Pharmacy: **Pharmacy Phone #**
LIST MEDICATIONS WITH DOSAGE YOU ARE PRESENTLY TAKING
(INCLUDING ASPIRIN, ORAL CONTRACEPTIVES & VITAMIN SUPPLEMENTS)