EAR NOSE & THROAT OF LAFAYETTE

A UNITY HEALTHCARE PARTNER

Name__________________________________ Date of Birth______________ Age _____ Date________________

Primary Care Physician: ____
Referring Physician: ____

PAST MEDICAL HISTORY: Please check any that apply to your health:

❑ Allergy problem ❑ Diabetes ❑ Heart Attack ❑ Lung Disease
❑ Asthma ❑ Reflux ❑ Hepatitis ❑ Seizures
❑ Bleeding Disorders ❑ Glaucoma ❑ Hypertension ❑ Sleep Apnea
❑ Cancer: Type___________ ❑ Heart Disease ❑ Kidney Problems ❑ Stroke
❑ Other____

List any surgeries:____
____

List any illnesses for which you were hospitalized:
____

List all current medication: (Amount, Times a day) Include nasal sprays:____

List medication allergies ____

SOCIAL HISTORY: Please check all that apply:

❑ Currently Smoke How many packs daily________ How many years________________
Did you previously smoke? When did you quit? ____________ Use smokeless tobacco?_______________
Any smokers in the home? ❑ Y ❑ N

Alcohol Use: ❑ None ❑ Rare ❑ Minimal ❑ Moderate ❑ Heavy

If in a daycare: ❑ Private ❑ Public Grade in School ______________

Occupation ________________________________

FAMILY HISTORY: Please check whether any relatives have following illnesses:

❑ Allergy ❑ Cancer Type_______________________________________
❑ Anesthesia ❑ Hearing Loss
❑ Bleeding Disorder ❑ Heart Problems ❑ Diabetes

Please check symptoms that relate to you:

❑ Chills ❑ Fatigue ❑ Weight Loss or Gain ❑ Dry skin ❑ Skin discoloration
❑ Rash ❑ Hives ❑ Skin ulcerations ❑ Itchy eyes ❑ Watery eyes
❑ Pain around eyes ❑ Asthma ❑ Cough ❑ Coughing ❑ Shortness of breath
❑ Wheezing ❑ Heartburn ❑ Reflux ❑ Swallowing difficulty
❑ Headaches ❑ Fainting ❑ Seizures ❑ Hot flashes
❑ Thyroid Problems ❑ Anemia ❑ Bleeding tendency ❑ Bruises easily
❑ Swollen Nodes/glands ❑ Chest pain ❑ Heart murmur ❑ Heart trouble
❑ High blood pressure ❑ Palpitations ❑ Heart attack ❑ Arthritis ❑ Joint pain
❑ Back pain ❑ Muscle Weakness

Physician Signature:____Date:_________________

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_______________ **Intl**

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_______________ **Intl**

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $200.00, whichever is greater.

_______________ **Intl**

MEDICARE CERTIFICATION: I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_______________ **Intl**

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is my cell phone or land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me.

_______________ **Intl**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

_______________ **Intl**

Patient Name/Signature: ____ Date:____________
Parent/Guardian Signature: ______________________________________ Date:____________