PREMIER ENT

Dr. G. Lee Watkins

PATIENT INFORMATION

Patient Name (First, Middle, Last): _____

Date of Birth: _____ Age: _____ Sex: [ ] Male [ ] Female

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Phone: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widow/Widower

PCP: _____ Referred By: _____

Patient SS#: _____ Email: _____

Do you consent to receive email notifications regarding your care, appointments, and upcoming events? [ ] Yes [ ] No

Patient portals help encourage better physician-patient relationships and give patients more control over their treatment. They are able to check lab results, request prescription refills, update insurance information, manage any unpaid balances and more. Would you like to be web enabled for the patient portal? [ ] Yes [ ] No

Emergency Contact Full Name (someone who does not live with you): _____

Emergency Contact Phone#: _____ Relationship to Patient: _____

Spouse Full Name: _____ Spouse Phone #: _____

Race:

[ ] American Indian [ ] Asian [ ] Black or African American [ ]White or Caucasian

[ ] Native Hawaiian [ ] Prefer not to Answer

Ethnicity:

[ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Prefer not to answer

Preferred Language:

[ ] English [ ] Spanish [ ] Other: _____

Patient Name (Print) Signature Date

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PATIENT INFORMATION

IF PATIENT IS A MINOR:

Father:_____ Home #: _____

Work #: _____ Cell#: _____

Mother:_____ Home #: _____

Work #: _____ Cell#: _____

RESPONSIBLE PARTY: [ ] CHECK HERE IF SAME AS PATIENT

Name (First, Middle, Last): _____

Date of Birth: _____ SSN of Responsible Party: _____ Sex: [ ]Male [ ]Female

Address/City/State/Zip: _____

Relationship to Patient: _____ Preferred Phone: _____

INSURANCE INFORMATION (Please allow us to make a copy of your Insurance Card(s) and Driver's License)

PRIMARY INSURANCE:

Insurance Company: _____ Member ID: _____ Group#:_____

Insurance Company Phone#: _____ SSN of Policyholder: _____

Insurance Address: _____

Policyholder Name: _____

Relationship to Patient: _____ Date of Birth:_____

SECONDARY INSURANCE:

Insurance Company: _____ Member ID: _____ Group #: _____

Insurance Company Phone #: _____ SSN of Policyholder: _____

Insurance Address: _____

Policyholder Name: _____

Relationship to Patient: _____ Date of Birth:_____

Patient Name (Print) Signature Date

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PATIENT INFORMATION

DATE: _____

NAME: _____ DATE OF BIRTH: _____

PHARMACY: _____ Pharmacy Phone#: _____

MEDICATIONS

List all current medications including prescription, over the counter, vitamins, herbals, and 'as needed' medications.

☐ **Check here if patient is not taking any medications at this time.**

Medication Name	Dose	How Often

ALLERGIES

List all allergic reactions to medications and/or medical supplies (ex: latex, tapes, adhesives, band-aids, iodine)

☐ **Check here if patient has no known drug allergies.**

Allergic To:	Reaction:

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NAME: _____ DATE OF BIRTH: _____

SURGICAL HISTORY

List all surgeries or hospitalizations you have had and approximate month/year

SURGERY/HOSPITALIZATION	MONTH/YEAR

Family/Medical History

Please place a check mark under all that apply.

	SELF	Father	Mother	Children	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Diabetes								
High Blood Pressure								
Heart Disease								
Anesthesia Complications								
Hearing Loss								
Recurrent Ear Infections								
Allergies								
Thyroid Problems								
Cancer								

☐ Patient is adopted

☐ Family History is unknown

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Authorization to Release Protected Health Information

PATIENT NAME:_____

DATE OF BIRTH: _____

PARENT/GUARDIAN NAME: _____

CHILDREN (FAMILY MEMBERS ONLY)

Please list all persons that may bring your child to the clinic and that we may talk to regarding your child's care and treatment. (Example: Grandparents, Aunts/Uncles, Etc.)

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ONLY PARENTS OR LEGAL GUARDIANS CAN SIGN CONSENTS FOR SURGERY

ADULTS (FAMILY MEMBERS ONLY)

Please list all persons that we may talk to regarding your care and treatment.

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

MY AUTHORIZATION EXTENDS TO ANY AND ALL RECORDS, UNLESS OTHERWISE MARKED BELOW

- ☐ Progress Notes
- ☐ Records of all visits
- ☐ Photographs or digital images
- ☐ Statements of charges or payments
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ History and physical examination
- ☐ Other (must be specific): _____

_____

Signature Date

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Patient Name: _____

Date of Birth: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made in order to manage the care you receive. Premier ENT understands that the medical information that is recorded about you and your health is personal. The confidentiality of your health information is also protected under both state and federal law. This notice of privacy practices describes how Premier ENT may use and disclose your information and the rights that you have regarding your health information.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. You will be notified if the request cannot be granted.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will accommodate reasonable requests.
- **Ask us to limit what we use and share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may deny this if it will affect your care. If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will typically agree unless a law requires us to share that information.
- **Get a list of those with whom we have shared information.** You can ask for a list (accounting) of the times we have shared your health information, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has that authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint by contacting our office at 318-716-1111. Please ask to speak to Dr. Watkins for this matter. We will not retaliate or act against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in disaster relief situation
  - Include your information in a hospital directory
  - Contact you for fundraising efforts, but you can tell us not to contact you again

Patient/Guarantor Signature: _____ Date: _____

- If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission to:

- Marketing purposes
- Sale of your information

PREMIER ENT USES AND DISCLOSURES:

We typically use or share your health information in the following ways:

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we can give information about you to your health insurance plan so it will pay for your services.
- **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

PREMIER ENT RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us otherwise, you may change your mind at any time. Let us know in writing if you change your mind.

AUTHORIZATIONS:

- **Appointment reminders** We may contact you to provide appointment reminders
- **Treatment information** We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- **Disclosure to Department of Health and Human Services** We may disclose your medical information when required by the US Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.
- **Notification** Unless you object, we may disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.
- **Abuse or neglect** We may disclose your medical information when it concerns abuse, neglect, or violence to you in accordance with federal and state law.

CHANGE IN NOTICE OF PRIVACY PRACTICES:

Premier ENT reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact our office at 318-716-1111.

Patient/Guarantor Signature: _____ Date: _____