



# BUCKHEAD ENT

## ADULT PATIENT INFORMATION FORM

(Please Print)

Today's date:

### PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			*Social Security #:		Home phone #: ( )		
P.O. Box:	City:		State:		ZIP Code:		
Email Address:							

### EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone #: ( )
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### PATIENT EMPLOYER CONTACT INFORMATION

Occupation:	Employer:	Employer phone #: ( )	
Address:	City:	State:	ZIP Code:

### SPOUSE INFORMATION (Complete only if insurance coverage is provided by spouse employer)

Full Name:	Social Security no.:	Date of Birth: / /
Employer:		

### PATIENTS PRIMARY CARE

Patients Primary Care Doctor's Name:
Patients PCP's Phone #:
Referring Doctor's Name (if different than PCP):
Referring Doctor's Phone #:

\*SS#'s are required for collection purposes. If you do not wish to provide your SSN, you will be considered a self-pay patient & expected to pay for visit at time of service.

Signature: \_\_\_\_\_ Name Printed: \_\_\_\_\_

Relationship: \_\_\_\_\_ (if not the patient receiving services) Date: \_\_\_\_\_



# BUCKHEAD ENT

## PATIENT CURRENT SYMPTOM FORM

Please Print

Dr. Keith M. Dockery, M.D.

Today's Date: \_\_\_\_\_

Patient Name:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

**Why are you here today?** Please write one paragraph describing your history. Please include **current symptoms**, and **how it has been treated** (include any prescriptions and over the counter medications, which you have taken for this condition). List any X-ray or Lab studies that have been done.

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• **How long have you had this problem?** \_\_\_\_\_

• **What is your occupation?** \_\_\_\_\_

• **What is your marital status?** (Check one)

Single  Married  Partnered  Divorced  Widowed

• **Are you a smoker?** (Check one)  Yes  No  Former

If you selected "yes" or "former", how much did you smoke? \_\_\_\_\_ packs per

(Check one)  Day  Week  Social Smoker  Rarely Smoked

If you have quit smoking, what year did you quit? \_\_\_\_\_

• **Do you drink alcohol?** (Check one)  Yes  No  Former

If you selected "yes" or "former", how often do you drink? \_\_\_\_\_ # of drinks

(Check one)  Daily  Weekly  Monthly  Rarely Drink

If you have quit consuming alcoholic beverages, what year did you quit? \_\_\_\_\_

• **Have you used any recreational drugs in the past?** (Check one)  Yes  No

Patient Name:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Family History (Check one)**

Is there a family history of allergies or asthma?  Yes  No

Is there a family history of head and neck cancer?  Yes  No

Is there a family history of hearing loss?  Yes  No

Is there a family history of thyroid cancer?  Yes  No

**Surgical History (Check one)**

Do you have a history of any ear, nose, or throat surgeries?  Yes  No

If yes, select the surgeries you had and write the approximate year(s) it was done.

**Ears:**  Tubes  Tympanoplasty  Mastoidectomy  Stapedectomy

Other: \_\_\_\_\_

Year: \_\_\_\_\_

**Nose:**  Rhinoplasty  Septoplasty and/or inferior turbinate reduction

Endoscopic Sinus Surgery  Nasal Fracture Repair

Other: \_\_\_\_\_

Year: \_\_\_\_\_

**Mouth:**  Adenoidectomy  Tonsillectomy  Adenoidectomy and Tonsillectomy

UPPP (Uvulopalatopharyngoplasty)  Midfacial advancement for overbite

Other: \_\_\_\_\_

Year: \_\_\_\_\_

**Neck/Throat:**  Excision of lymph node  Excision of salivary gland  Excision of neck mass

Thyroidectomy  Tracheotomy  Vocal Cord Surgery

Other: \_\_\_\_\_

Year: \_\_\_\_\_

List other **MAJOR** surgeries that you have had and the year it was done:

\_\_\_\_\_  
\_\_\_\_\_

List any **DRUG ALLERGIES** and the reaction:

Medication Name	Adverse Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Do you have LATEX allergies?  Yes  No

**Environmental and Food Allergies (Check one)**

Do you have any environmental allergies?  Yes  No

Do you have allergy symptoms all year long?  Yes  No

Have you ever had an allergy test before?  Yes  No

Have you ever been on allergy shots?  Yes  No

Do you have a history of hives or rash?  Yes  No

Do you have a history of food allergies?  Yes  No

Do you have a chronic postnasal drip?  Yes  No

Do you get recurring sinus infections?  Yes  No

Do you wheeze or have trouble breathing?  Yes  No

**Ear Problems**

Do you have any problems hearing?  Yes  No

Do you have ringing in your ears?  Yes  No

Do you have any dizziness or vertigo?  Yes  No

Do you have regular ear pain or itching?  Yes  No

When was your last hearing test? \_\_\_\_\_ Was it normal?  Yes  No

**Voice Problems**

Do you have any hoarseness?  Yes  No

Do you have any swallowing problems?  Yes  No

Do you have heartburn or acid reflux?  Yes  No

Do you cough or clear your throat frequently?  Yes  No

Do you have chronic sore throat?  Yes  No



# BUCKHEAD ENT

## PATIENT INSURANCE FORM

(Please Print)

### Current/Valid Insurance Card Required

Buckhead ENT **MUST** have a copy of your current insurance card or you will be expected to **PAY IN FULL** at the time of service. If your insurance changes and you fail to give a current insurance ID card, you will be responsible for service's that were rendered before we receive a current ID card. We will not resubmit your insurance for any dates of service. However, you may file those claims yourself so that you may be reimbursed.

### Primary Insurance Information

Insurance Company Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

### Secondary Insurance Information

Insurance Company Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

### Guarantee of Payment for Services & Assignment of Benefits

It is the policy of this office that payment must be received when services are rendered, except in case of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office, if you have any questions.

- In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. If this account is placed with attorney or outside collection agency, the undersigned parties agree to pay all reasonable attorney fees and cost of collection. Initial \_\_\_\_\_

- I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information in the processing of this claim. Initial \_\_\_\_\_

- I hereby attest that I have read and understand the statements, guarantee of payment and assignment of benefits outlined above completely. Initial \_\_\_\_\_

Signature: \_\_\_\_\_ Name Printed: \_\_\_\_\_

Relationship: \_\_\_\_\_ (If not the patient receiving services) Date: \_\_\_\_\_



# BUCKHEAD ENT

## OFFICE FINANCIAL POLICY

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our financial policy in order to minimize misunderstandings about fees and collection processes. Our fees and collection methods are comparable with those of other ENT specialists in the Atlanta area.

Our financial policies include these requirements:

1. We require complete and honest information on your patient information sheet.
2. We require a copy of your ID card with picture.
3. We require your Social Security Number.
4. We require that co-pays be paid at the time of your visit before seeing the specialist.
5. **We add a finance charge of 21% to any balance that exceeds 60 days.**
6. We expect that past due balances, deductibles and coinsurance balances will be paid before surgery is scheduled.
7. We require that self-pay patients will pay their charges at the time services are rendered, or make arrangements to pay their charges before the visit with our specialists.
8. If your insurance company has a pre-existing clause, coverage for services may be denied. Payment for these services will be your responsibility.
9. We will file to primary and secondary plans only. If you have a third insurance plan, we will be pleased to provide the information so you can file them.
10. If we have to send your account to an outside collection agency, we will add collection and finance fees to the outstanding balance. This is usually 50% of the past due balance added to your account. You may be dismissed as a patient as the discretion of the physician.
11. We accept cash, personal checks, money orders, VISA, MasterCard, Discover card and Care Credit.
12. If your bank returns a personal check, we will add a \$25 fee to your account.
13. If your insurance plan requires a referral for services provided by a specialist, and you fail to obtain one from your PCP listed on your insurance card you will be rescheduled until you obtain a referral.
14. **We charge a \$20 fee for missed appointments. To avoid this charge you must give at least a 24-hour notice of your cancellation.**

This policy is offered by Buckhead ENT in an attempt to develop and sustain a continued professional and pleasant relationship with our patients.

Please read our policy carefully before signing. Please don't hesitate to ask our staff before signing if you have any questions or concerns.

I have read and understand this financial policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# BUCKHEAD ENT

2045 Peachtree Road N.W.  
Suite 500  
Atlanta, GA 30309  
(404) 350-7966

Dr. Keith M. Dockery, M.D.

## **Patient Consent for the Use and Disclosure of Protected Health Information**

I hereby give my consent for Buckhead ENT to use and disclose protected health information (PHI) about me to carry out treatment, billing and routine healthcare operations of our medical practice. I have read the Notice of Privacy Practices, which provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Janice Willis, at Buckhead ENT's office at 2045 Peachtree Road, Suite 500, Atlanta, GA 30309.

With consent, Buckhead ENT may call my home or other alternative locations and leave a message or voicemail regarding appointment reminders, insurance collection items, and any calls pertaining to my clinical care, including laboratory, MRI, CT, or sleep study results.

With this consent, Buckhead ENT may mail to my home or alternative location any items that assist the practice in carrying out their healthcare operations.

With this consent, Buckhead ENT may email to my home or alternative location any items that assist the practice in carrying out their healthcare operations.

I have the right to request that Buckhead ENT restrict how it uses or discloses the Protected Health Information (PHI) to carry out their healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Buckhead ENT's use and disclosure of my PHI to carry out their healthcare operations.

I may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Buckhead ENT may decline to provide treatment to me.

### **I wish to be contacted in the following manner**

*(Please check all that apply)*

**Home Telephone** \_\_\_\_\_

- OK to leave message with detailed information
- Leaving message with call-back number only

**Work Telephone** \_\_\_\_\_

- OK to leave message with detailed information
- Leaving message with call-back number only
- OK to fax to this number

### **Written Communication**

- OK to mail to my home address
- OK to mail to my work/office address

I understand that by signing this form, I am giving Buckhead ENT., specifically Dr. Keith M. Dockery, the authorization to use my protected health information to carry out their healthcare operations. I further understand that Buckhead ENT cannot guarantee the confidentiality of my PHI when leaving messages on the telephone answering machines or on voice mail lines.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_