BROWARD ENT CONSULTANTS, PL

5511 North University Driv
Suite 101B
Coral Springs, FL 33067
Phone: (954) 755-4002
Fax: (954) 755-5010
http://www.myentmd.com

ADULT PATIENT MEDICAL HISTORY

Name: _____
DOB: _____Height___ Weight_____
Today's date: _____
Referring doctor: _____
Previous ENT consultations:_____

What is the main reason for today's visit?

_____

How long has this been a problem? ____Hours ____Days____Weeks____Months____Years

Have you taken any over the counter medications or prescription medication for this problem. If yes, please list.

_____

Have X-rays, CT scans, MRI's, sleep study or allergy tests been obtained for this problem? If yes, please list.

_____

Past and present medical history that require regular doctor visits or medication: (please check)

__ Allergies
__Anemia
__Anxiety
__Asthma
__Bleeding problems
__Cancer(type)_____
__Diabetes
__Dizziness
__Eye Disease
__ Emphysema/COPD
__Stroke
__Gastrointestinal problems/Acid Reflux/Hiatal Hernia
__Heart Disease/High Blood Pressure
__Hepatitis
__HIV/AIDS
__Leukemia/Lymphoma
__Liver/Kidney Disease
__Lupus/Autoimmune Disease
__Migraine/Headaches
__Recurrent Sinus Infections
__Sleep Apnea (Diagnosed by a physician)
__Thyroid Problems

Other if not listed above_____

List ALL medications, including aspirin, herbal medications, over the counter medicines and vitamins you take on a regular basis with the doses:

_____

_____

_____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO INCLUDING (LATEX/NATURAL RUBBER):

_____

FAMILY HITORY: PLEASE LIST ANY BLOOD RELATIVES THAT HAVE OR HAVE HAD ANY OF THE FOLLOWING:
HEARING LOSS____HOW ARE YOU RELATED?_____
HEART TROUBLE____HOW ARE YOU RELATED_____
BLEEDING/CLOTTING PROBLEMS____HOW RELATED_____
CANCER____HOW ARE YOU RELATED_____
ASTHMA/ALLERGIES____HOW ARE YOU RELATED_____
SLEEP APNEA/USES CPAP____HOW ARE YOU RELATED_____

Surgical History: Please list all previous surgeries with approximate dates:

_____

_____

SOCIAL HISTORY:

Have you ever been a smoker? ___Yes___No If yes,____packs per day, ____years? Smokeless Tobacco: __Yes__No
If you quit, how long ago?_____
Do you drink alcohol? ___Yes___No If yes, how many drinks per day?___week___month___

Who lives at home with you?_____

Review of systems: PLEASE CHECK ANY MEDICAL PROBLEMS YOU ARE CURRENTLY HAVING INCLUDING SYMPTOMS INWHICH CONTRIBUTE TO TODAY'S VISIT?

BODY(GENERAL):
Fatigue__
Trouble sleeping__
Weight loss/Weight gain__
Chronic Pain__

EYES
Blurred vision__
Glaucoma__
Itching__
Pain__

EARS
Ear infections__
Decreased hearing__
Ear fullness/clogging sensation__
Ear pain__
Dizziness/Imbalance__
Ringing/noise in the ears__
History of noise exposure__

NOSE
Nasal discharge__
Nasal congestion/stuffiness__
Changes in sense of smell__
Nasal polyps__
Frequent colds__
Sinus infections__ How many per year? ___
Broken nose__
Nasal bleeding__
Allergies__
Sneezing__

THROAT
Sore throat__
Tonsillitis__ How many per year that required antibiotic therapy? __
Bad breath__
Hoarseness__
Snoring__
Noisy breathing__
Cough__
Throat drainage__

NECK
Large glands__
Neck pain__
Lump/Cyst__
Thyroid problems__

HEART
Murmur__
Heart Surgery__
Heart Attack__
Chest Pain

LUNGS
Asthma__
Wheezing__
Bronchitis__
Bloody cough__
Emphysema/COPD__

STOMACH
Heartburn__
Stomach Cramps__
Stomach Ulcer__
IBS__

MUSCLE/BONES
Joint Pain__
Joint Swelling__
Weakness __
Back Pain__

PSYCH
Depression__
Insomnia__
Anxiety/panic attacks__

SKIN
Eczema__
Itching__
Hives__
Rash__
Moles__

GU
Frequency__
Burning__
Stones__
Bleeding__
Infections__

BROWARD ENT
CONSULTANTS, PL

Ram K. Madasu, M.D.,FACS

Victoria Rojas, Au.D, RN

PATIENT INFORMATION

PATIENT NAME:_____
Last First Middle

SSN:_____ DATE OF BIRTH:_____ SEX: F M

MARITAL STATUS: S M W D

Home
Address:_____
Street City ST Zip Code

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Spouse Phone #_____

PRIMARY CARE PHYSICIAN:_____PHONE#_____

PHARMACY NAME:_____PHONE #_____

EMAIL ADDRESS_____

INSURED NAME_____D.O.B_____

INSURANCE NAME_____PPO/HMO

INSURANCE ID #_____

ASSIGNMENT AND RELEASE

I, The undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. Madasu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature_____ Date_____

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BROWARD ENT
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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *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 understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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Cancellation Policy/No Show Policy/Same Day Cancellation

Cancellation/ No Show Policy for Dr.Madasu Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

I hereby understand that Dr. Madasu; Broward ENT consultations will contact you the day before your appointment and if we do not receive a confirmation back then the appointment will be cancelled.

If you have a Monday morning appointment; we must hear back from you to confirm this appointment by Friday afternoon; your appointment will be cancelled.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If you arrive 15 minutes past your scheduled appointment time we will have to reschedule the appointment.

Account balances

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

_____

Patient Signature Patient/Guardian

____/____/____

Date

Patient Account #_____

(Office Use Only)

AUTHORIZATION TO RELEASE INFORMATION

I HEARBY GIVE MY PERMISSION TO **BROWARD ENT CONSULTANTS** TO RELEASE A COPY OF MY MEDICAL RECORDS (ANY DIAGNOSTIC TESTING/ALLERGY TESTING/PHYCIANS NOTES VISIT NOTES/OP REPORTS OR OTHER LISTED BELOW)

OTHER _____ DATE _____

PATIENTS SIGNATURE _____ DATE _____

ADDRESS: 5511 N. UNIVERSITY DR. SUITE 101B CORAL SPRINGS FL, 33067
PHONE NUMBER: 954-755-4002 FAX NUMBER: 954-755-5010

I HEARBY RELEASE THE FACITILY FROM ANY LIABILITY WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED

PATIENTS NAME PRINTED _____ DATE _____

PATIENTS NAME SIGNED _____ DATE _____

THE INDIVDIUAL AUTHORIZING THE RELEASE OF SUCH INDIVIDUALS INFORMATION, OR THE PERSON AUTHORIZED TO ACT ON BEHALF OF THE INDIVIDUAL, OR THE INDIVIDUAL'S AUTHORIZED REPRESENTATIVE IS ENTITILES TO RECEIVE A COPY OF THIS AUTHORIZATION FORM UPON PRESENTING DOCUMENTATION SETTING OUT THE AUTHORIZATION TO ACT ON BEHALF OF SUCH INDIVIDUAL

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFIYING THE PROVIDING ORGANIZATION IN WRITING, BUT IF I DO, IT WONT HAVE ANY AFFECT ON ANY ACTIONS THEY TOOK BEFORE THEY RECEIVED THE REVOCATION

I HEARBY AUTHORIZE THE RELEASE OF MY RECORDS AND AUTHORIZATION TO DISCLOSE INFORMATION TO THE FOLLOWING

NAME _____ SIGNATURE _____

CONTACT _____ RELATIONSHIP _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY

PATIENTS NAME _____ DATE OF BIRTH _____

MINORS/REPRESENTATIVES/POWER OF ATTORNEY _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
YOU MAY NOT USE THIS FORM TO RELEASE INFORMATION FOR TREATMENT OR PAYMENT EXCEPT WHEN THE INFORMATION TO BE RELEASED IS PSYCHOTHERAPY NOTES OR CERTAIN RESEARCH INFORMATION.