RiverENT
Adult & Pediatric Ear, Nose & Throat Specialists

Original Date:	
Dates Revised:	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Primary care Physician (PCP):**	
Preferred Pharmacy:		
Employment status:	☐ Employed ☐ Not Employed ☐ Retired Occupation: _____	
Race & ethnicity:	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Hispanic or Latino ☐ Other: _____	
Language preference:	☐ English ☐ Spanish ☐ Other:_____	

How did you hear about us?	☐ Internet Search ☐ Family Member ☐ Friend ☐ Physician ☐ Advertisement ☐ Other: _____
Has any member of your family been seen by any of the physicians at River ENT? If yes, specify:	
Reason for today's visit:	

PATIENT HEALTH HISTORY

PAST MEDICAL HISTORY

☐ Allergy Testing	☐ Bleeding Disorder	☐ Kidney Disease
☐ Anxiety	☐ Heart Disease	☐ Laryngitis
☐ Asthma	☐ Heartburn (reflux)	☐ Liver Disease/Hepatitis
☐ Diabetes	☐ High Blood Pressure (hypertension)	☐ Pharyngitis
☐ Emphysema/COPD	☐ High Cholesterol (hyperlipidemia)	☐ Sinusitis
☐ Hearing Loss	☐ Human Immunodeficiency Virus (HIV)	☐ Sleep Apnea
☐ Cancer, type: _____	☐ Other: _____	☐ Thyroid Disorder
If treated, how: _____	_____	☐ Vertigo/Dizziness

PAST SURGICAL HISTORY

Year	Reason	Hospital

FAMILY HEALTH HISTORY	
Relation to Patient	Medical Condition

HEALTH HABITS					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.					
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
For Children Only (under 17 years of age)	Are immunizations up to date?			☐ Yes	☐ No
	Gestation?			_____weeks	
	Pregnancy or Perinatal Problems?			☐ Yes	☐ No
	Is there a history of neonatal ICU (NICU) stay at time of birth?			☐ Yes	☐ No
	If yes, for what reason?				
	Is there a history of smoke exposure, including secondary smoke exposure?			☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

ACKNOWLEDGEMENTS /CONSENTS / FINANCIAL RESPONSIBILITY/ DISCLOSURES

_____ **(initial) RECEIPT OF HIPAA PRIVACY NOTICE AND PATIENT NOTICES**

I have reviewed a copy of River ENT's HIPAA Privacy Notice and Patient Notices (Also available at www.river-ent.com under patient forms.)

_____ **(initial) CONSENT TO TREATMENT**

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I understand that I have the right to refuse any medical or surgical treatment that I do not want.

_____ **(initial) FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS**

I understand that copays, deductibles/co-insurance will be collected at the time service. I further understand that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier including Medicare. WE STRONGLY RECOMMEND THAT YOU READ YOUR INSURANCE BOOKLET OR CALL YOUR INSURANCE COMPANY REQUESTING A BENEFIT DESCRIPTION FOR A SPECIALIST OFFICE. I understand that my insurance may process certain services (e.g. nasal endoscopy, nasal debridement) as a diagnostic or surgical procedure and may be applied towards my deductible/coinsurance. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to River ENT for services rendered to me. I understand I will be responsible for these charges if the claim is denied or is not paid in a timely manner.

Should my account become a collection problem, River ENT has the right to discharge you as a patient. I understand I will be financially responsible for any additional fees incurred during the collection process. I also understand that all past due accounts must be paid in full prior to making any future appointments.

We request that at least 24-hour advance notice be given to our office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of $45.00 for no-shows. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Fees: Returned check fees: $35.00 Missed appointments: $45.00 Paperwork Preparation: $25.00

Medical Records: $25 for 1-20 pages and 50 cents for each page thereafter

I understand, when required by my insurance plan, I am responsible for obtaining referrals from my Primary Care Physician prior to receiving treatment from a River ENT provider. If said referral is not on file with River ENT at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

I understand that any quote provided is an estimate based upon my insurance benefits at the time of verification.

The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (e.g., percentage of financial responsibility), and will not bill a divorced spouse for the patient's services.

I authorize River ENT to discuss my healthcare account with the following person(s)/entity(ies). Any changes to this document must be made in writing. I release River ENT and its employees from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

Name	Phone	Relationship

_____ **(initial) DISCLOSURE OF PHYSICIAN OWNERSHIP**

Please carefully review the information contained in this notice and feel free to ask any questions.

- You have the right to choose the provider of your health care services. Therefore, you may choose to have CT scans performed at a location other than River ENT. You may ask the front desk for a list of alternate locations in our area, if you choose.
- The physicians at River ENT will not treat you differently if you choose to obtain health care services at a facility other than those listed above.
- Speech pathology services provided at River ENT will be billed by Loraine Stuart, MS, CCC-A/SLP, not by River ENT.

If you have any questions concerning this notice or anything in it, please feel to ask your physician or a River ENT representative. Please acknowledge your receipt and understanding of this notice by your signature below.

My signature below indicates that I have read and agree with all statements that I have initialed above.

Signature of Patient (or Guardian)	PRINTED Name of Patient	Date of Birth	PRINTED Name of Guardian	Date