Coastal Carolina Otolaryngology

Patient Information

Please fill out this page in its entirety. Thank you!

Name: _____ Preferred Name: _____

Last, First, Middle Initial

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ D ☐ W

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell: _____ Home: _____

Employer: _____ Work: _____

Email: _____

Local Pharmacy Information

Please include a local pharmacy; if you do not have one, please let the front office staff know.

Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone: _____

Guarantor/Guardian (For patients UNDER 18 years of age)

Name: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Legal Guardian? ☐ YES ☐ NO (Guardianship documentation is **required** at time of check-in.)

Emergency Contact Information

Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Primary: _____

Secondary: _____

Policyholder Information

Please make sure to fill out this portion if the patient is not the policyholder. We need this information in the event we have to schedule surgeries or procedures and to obtain billing benefits.

Name: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Signature: _____ Date: _____

Or Signature of Parent/Guardian if Under 18 Years of Age

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Patient Medical History Questionnaire

Name: _____ Date: _____

Medical History

Please list all illnesses (e.g., cancer, diabetes, high blood pressure, stroke, heart attack, etc.).

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History

Please list all of the surgeries that you have had and the approximate date performed.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History

Please list all illnesses that run in your immediate family. List maternal or paternal, including grandparents.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Do you currently smoke or use tobacco products: ☐ Y ☐ N

If yes, age started? _____ How much per day? _____

If you are a former smoker, at what age did you start/stop? _____ / _____

Do you drink alcoholic beverages? _____ How much in an average week? _____

Allergy History

Please list all allergies (both to medications and environmental allergens) that you have.

_____ _____ _____

_____ _____ _____

Current Medications

Please list all current medications and their dosages if known, or allow us to copy your list.
**Include over-the-counter medications.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

***** Please complete the backside of this form. *****

3822 Mayfair Street, Myrtle Beach, SC 29577 | **Phone: (843) 449-6449**
1120 Glenns Bay Road, Suite 117, Surfside Beach, SC 29575 | **Phone: (843) 215-1068**

Is there a possibility that you may be pregnant? ☐ Y ☐ N
Have you had or do you have hepatitis? ☐ Y ☐ N
Have you had or do you have HIV? ☐ Y ☐ N

Review of Systems: Please answer the following questions regarding how you feel currently.
Do you or have you recently had any of the following?

EYES
Visual changes in the past year? ☐ Y ☐ N
Glaucoma? ☐ Y ☐ N
Double or blurred vision? ☐ Y ☐ N
Pain, redness or dryness? ☐ Y ☐ N

EARS
Do you currently wear hearing aids? ☐ Y ☐ N
Date of purchase? _____
Hearing problems? ☐ Y ☐ N
Ringing in the ears? ☐ Y ☐ N
Discharge from the ears? ☐ Y ☐ N
Loss of balance/vertigo? ☐ Y ☐ N
Ear pain? ☐ Y ☐ N
Pressure in the ears? ☐ Y ☐ N
Frequent ear infections? ☐ Y ☐ N
History of loud noise exposure? ☐ Y ☐ N

NOSE
Nasal congestion? ☐ Y ☐ N
Nasal discharge? ☐ Y ☐ N
Post-nasal drip? ☐ Y ☐ N
Loss of smell? ☐ Y ☐ N
Frequent nosebleeds? ☐ Y ☐ N
Snoring? ☐ Y ☐ N
Injury to the nose? ☐ Y ☐ N
Nasal or sinus surgery? ☐ Y ☐ N
Frequent sinus infections? ☐ Y ☐ N

THROAT
Sore throat? ☐ Y ☐ N
Frequent throat infections? ☐ Y ☐ N
Painful or difficult swallowing? ☐ Y ☐ N
Hoarseness? ☐ Y ☐ N

HEART
Heart problem? ☐ Y ☐ N
High blood pressure? ☐ Y ☐ N
Angina/chest pain? ☐ Y ☐ N

CHEST
Asthma? ☐ Y ☐ N
Bronchitis? ☐ Y ☐ N
Shortness of breath? ☐ Y ☐ N
Wheezing? ☐ Y ☐ N
Chronic cough? ☐ Y ☐ N
Cough up blood? ☐ Y ☐ N
History of tuberculosis? ☐ Y ☐ N

DIGESTIVE
Heartburn/ulcers? ☐ Y ☐ N

BLOOD
Anemia? ☐ Y ☐ N
Easy bruising? ☐ Y ☐ N
Received transfusions? ☐ Y ☐ N

Office Use Only
Height _____ Temp _____
Weight _____ Pulse _____
B/P _____

The above information is true and correct to the best of my knowledge.

Printed Name: _____

Signature: _____ **Date:** _____

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CCOA

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

CCOA is authorized to release protected health information about the above-named patient to the entities listed below.

Entity(ies) to Receive Information

Spouse

Name: _____ Phone: _____

This entity may receive health information about:

☐ Clinical information ☐ Billing information ☐ All

Parent

Name: _____ Phone: _____

This entity may receive health information about:

☐ Clinical information ☐ Billing information ☐ All

Other

Name: _____ Phone: _____

This entity may receive health information about:

☐ Clinical information ☐ Billing information ☐ All

☐ **Information is not to be released to anyone but me.**

Voicemail

Please call: ☐ Home ☐ Cell ☐ Work

If unable to reach me:

☐ You may leave a detailed message. ☐ Please leave a message asking to return your call only.

I understand that I have the right to revoke this authorization at any time. I have the right to inspect or copy the protected health information to be disclosed asdescribed in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will be in effect until revoked by the patient.

Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____
(Street)

_____
(City) (State) (Zip)

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____ _____
(Signature) (Date)

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

☐ An emergency existed, and a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason: _____

☐ Other: _____

Prepared by: _____

Signature: _____

Date: _____

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COA

Financial Policy

If you are covered by health insurance, please provide your insurance information to the front office staff, and we will be happy to bill your insurance. Accepting your insurance information does not place any financial responsibilities onto this practice, and you will be held accountable for any unpaid balances.

Based on the limits of your insurance plan benefits, not all diagnostic tools and procedures performed by our practice may be considered inclusive with the office visit. You, the patient, would be financially responsible for any amount applied to your deductible, out-of-pocket expense, coinsurance amount or noninclusive amount. Co-payments are collected at the time of service. Any other balances are due upon receipt of a statement from our office.

No-show appointments are subject to a $35 missed appointment fee.

Completing insurance forms, copying medical records, etc., requires office staff time and physician time away from patient care, so we require payment for completing forms or copying medical records. The charge is determined by the complexity of the form, letter or communication.

I authorize the release of medical or other information necessary to process insurance claims, and I authorize payment of the medical benefits directly to this practice for services rendered.

Patient Name: _____ Date of Birth: _____

Parent or Responsible Party (if patient is under 18 years old): _____

Signature: _____ Date: _____