SOUTH HILLS ENT ASSOCIATION

Head and Neck Surgery • Thyroid and Parathyroid • Facial Plastics • Allergy • Sinus Surgery
Sleep Apnea • Otologic Surgery • Vestibular Disorders • Audiology • Hearing Aid Dispensing

Board Certified Physicians
David P. DeMarino, MD • Stephen F. Wawrose, MD • Paul Scolieri, MD • Brian R. Elford, DO
Heather Greening, MSN, CRNP

Licensed Audiologists
Barbara C. Fike, MA,CCC-A • Karen C. Kamon, MS,CCC-A • Leslie R. Battisti, AuD • Karen P. Wood, MEd,CCC-A

Your appointment is scheduled for

_____ at _____

with Dr. _____ at ❑ Bethel Park ❑ Jefferson Hills ❑ UPMC Outpatient Ctr.

We are delighted to welcome you to our practice and are pleased that you chose us to serve your ENT needs. We are serious about providing superior medical care and proud of our dedication to our patients.

To facilitate being seen as quickly as possible at the time of your appointment, please complete the following items:

Forms - Complete the enclosed forms in their entirety and bring them with you to your appointment. Please be sure to answer all of the questions on both forms. Please make sure that you list current medications, any allergies to medications, and previous surgeries. Please answer Yes or No to each question on the medical questionnaire.

Test Results - If you have had any testing pertinent to your problem, please obtain a copy of the results and bring them to our office. If you had an X-ray, MRI or CT Scan, it would be beneficial to bring the disc with you.

Insurance Cards - Please bring your insurance cards to the visit with you so that we can maintain a copy for our records.

Referrals - If your insurance company requires a REFERRAL, please contact your Primary Care Physician. Please call at least two weeks in advance, if possible. This will ensure that we will have the referral the day of your visit. If we do not have your referral at the time of your visit, you will be responsible for services rendered. Our fax number is listed below.

Co-payments and Deductibles - Please be prepared to pay for your co-payments and deductibles at the time of your visit. We accept cash, personal checks, MasterCard, Visa, Discover and American Express.

If you are unable to make the scheduled appointment, please notify us at least 24 hours in advance by calling 412-831-7570, extension 221.

Thank you again for choosing South Hills ENT Association.

Bethel Park
2000 Oxford Drive, Suite 201
Bethel Park, PA 15102
412-831-7570 • Fax: 412-854-6149

Jefferson Hills
575 Coal Valley Road, Suite 400
Jefferson Hills, PA 15025
412-831-7570 • Fax: 412-854-6149

UPMC Outpatient Center
275 Clairton Blvd.
West Mifflin, PA 15236
412-831-7570 • Fax: 412-854-6149

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PATIENT INFORMATION

PATIENT'S LAST NAME _____ **FIRST NAME**_____ **MI**_____

DOB_____ **SS#**_____

GENDER □ **MALE** □ **FEMALE** **MARITAL STATUS** □ Single □ Married □ Divorced □ Widowed □ Other

The following information is being asked to comply with the Meaningful Use Requirements for Electronic Medical Records. Failure to complete this part will be marked as declined for our record keeping.

RACE □ White □ Black/African American □ American Indian/Alaska Native □ Asian □ Nat. Hawaiian/Pac. Islander □ Unknown □ Declined

ETHNICITY □ Hispanic/ Latino □ Not Hispanic/Latino □ Unknown □ Declined

STREET ADDRESS _____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE NUMBER _____ **CELL PHONE NUMBER**_____

WORK PHONE NUMBER _____ **E-MAIL ADDRESS**_____

What is the best way to contact you? *Primary* □ *Home* □ *Cell* □ *Work*
Secondary □ *Home* □ *Cell* □ *Work*

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

PHARMACY NAME_____ **ADDRESS** _____ **PHONE**_____

EMPLOYER _____ **EMPLOYER'S ADDRESS** _____

CONSENT FOR MEDICAL CARE

I, _____, consent to medical evaluation and treatment by the physicians and employees of South Hills ENT Association. I understand that my medical evaluation and treatment may include certain diagnostic tests, including hearing and vestibular testing. In addition, my physician may determine that certain invasive procedures are necessary. I understand that I may be an active participant in my treatment. I also understand that I may withdraw my consent at any time.

_____ _____
Patient Signature **Date**

_____ _____
Authorized Party Signature **Date**

_____
Relationship to Patient

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2000 Oxford Drive • Suite 201
Bethel Park, PA 15102
412-831-7570 • Fax: 412-854-6149

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PRIMARY INSURANCE INFORMATION

POLICYHOLDER INFORMATION (This is the person who carries the insurance)

POLICYHOLDER NAME_____**DATE OF BIRTH**_____ **SS#**_____

ADDRESS(*IF DIFFERENT FROM PATIENT*) _____**CITY**_____**STATE** ____ **ZIP**_____

RELATIONSHIP TO PATIENT _____ _____

INSURANCE COMPANY NAME _____**ID #** _____

GROUP # _____ **RX GROUP #** _____

SECONDARY INSURANCE INFORMATION

POLICYHOLDER INFORMATION (This is the person who carries the insurance)

POLICYHOLDER NAME_____**DATE OF BIRTH**_____ **SS#**

ADDRESS (*IF DIFFERENT FROM PATIENT*) _____**CITY**_____**STATE** ____ **ZIP**_____

RELATIONSHIP TO PATIENT _____ _____

INSURANCE COMPANY NAME _____ **ID #** _____

GROUP # _____ **RX GROUP #**

IS YOUR VISIT A RESULT OF AN ACCIDENT? ___YES __NO TYPE: ___AUTO __WORK __OTHER

DATE OF ACCIDENT _____ *CLAIM NUMBER* _____

*THIRD PARTY INSURANCE NAME*_____*PHONE NUMBER* _____

*ADDRESS*_____ *CITY* _____ *STATE*_____ *ZIP*_____

FINANCIAL AGREEMENT

I authorize South Hills ENT Association to bill my insurance carrier and request such payments to be made directly to South Hills ENT Association. I assign all rights to insurance payments and benefits to which I am entitled for the services rendered to South Hills ENT Association.

I authorize South Hills ENT Association to release my medical or other pertinent information about treatment or service as required for reimbursement purposes to my insurance carrier and any entity contracted to collect for these services rendered, such as a Collection agency.

I agree to pay any amounts not paid by my insurance including deductibles, co-payments and non-covered services.

_____ _____

Patient Signature **Date**

_____ _____

Authorized Party Signature **Date**

_____

Relationship to Patient

SOUTH HILLS ENT
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PATIENT HEALTH HISTORY FORM

(Please fill out completely and bring to office)

Date: _____ **Name:** _____ **Age:**_____

CURRENT MEDICATIONS (Include Over the Counter) **ALLERGIES**

MEDICATION	REASON	DOSAGE		MEDICATION ALLERGIES	FOOD ALLERGIES	OTHER ALLERGIES

DO WE HAVE YOUR PERMISSION TO ACCESS YOUR MEDICATION HISTORY ELECTRONICALLY? YES _____ NO _____

SURGICAL HISTORY

TYPE OF SURGERY	DATE

PAST MEDICAL HISTORY -*Do you have or have you ever had?*

Arthritis	yes	no
Asymptomatic HIV	yes	no
Cancer	yes	no
Diabetes	yes	no
Gallbladder	yes	no
Heart Disease	yes	no
Hypertension	yes	no
Kidney Disease	yes	no
Liver Disease	yes	no
Lung Disease	yes	no
Thyroid Disease	yes	no

Anxiety Disorder	yes	no
Depression	yes	no
Glaucoma	yes	no
Head Trauma	yes	no
Hearing Loss	yes	no
Seizure	yes	no
Stroke or TIA	yes	no
Auto Immune Disease	yes	no
Bleeding Disorder	yes	no
Reaction to Anesthesia	yes	no

SOCIAL HISTORY

Children:	Number of Children _____ Ages _____ _____ _____ _____ _____ _____
Marital Status:	____Single ____ Married ____ Divorced ____ Widowed ____Other
Line of Work/Occupation:	_____

HEALTH HABITS

Do you use tobacco? ____No ___Yes _____packs per day ***For how many years***? _____ ***If you QUIT***, how many years ago?_____
Do you use alcohol? ____No ___ Yes _____Number of drinks __ ***Frequency*** __ day ____ week____ weekend ___ month
Do you use coffee, tea or caffeine containing beverages? ____No ____Yes ***Number of cups per day*** _____

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ASSOCIATION

Date: _____ Name: _____ Age: _____

FAMILY HISTORY

If any blood relatives have had any of the following, please circle and indicate which relative was affected

Anesthesia Problems	Diabetes	Mental Illness
Bleeding Easily/Blood Disorder	Hearing Loss	Stroke
Cancer	Heart Disease	Thyroid

INHERITED DISORDER _____

IMMUNIZATIONS

_____ Pneumonia	Date Of Last:	_____ Tetanus	Date Of Last:
_____ Diphtheria	Date Of Last:	_____ Mumps	Date Of Last:
_____ Flu	Date Of Last:	_____ Hepatitis	Date Of Last:
_____ HPV	Date Of Last:	_____Herpes Zoster	Date Of Last:

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

Please Yes or No to each question by circling the appropriate answer

Constitutional			**Mouth**			**Genitourinary**		
Fever	yes	no	Breath Odor	yes	no	Kidney Stone	yes	no
Night Sweats	yes	no	Dental Problems	yes	no	Kidney Disease	yes	no
Weight Change	yes	no	Dry Mouth	yes	no	**Integumentary**		
Weakness or Fatigue	yes	no	Gingival Bleeding	yes	no	Nail Changes	yes	no
Eyes			Mouth Pain	yes	no	Rash	yes	no
Vision Change	yes	no	Mouth Swelling	yes	no	Skin Dryness	yes	no
Itchy	yes	no	**Throat**			**Neurologic**		
Dryness	yes	no	Change in Voice	yes	no	Dizziness	yes	no
Neck			Difficulty swallowing	yes	no	Headaches	yes	no
Neck Mass	yes	no	Enlarged Tonsils	yes	no	Memory Difficulties	yes	no
Neck Pain	yes	no	Frequent Throat Clearing	yes	no	Seizures	yes	no
Swollen Glands	yes	no	Sore Throat	yes	no	Speech Difficulties	yes	no
Thyroid Mass	yes	no	**Cardiovascular**			**Musculoskeletal**		
Ears			Hypertension	yes	no	Joint Pain	yes	no
Ear Discharge	yes	no	Heart Problems	yes	no	Muscle Pain	yes	no
Ear Pain	yes	no	Irregular Heartbeat	yes	no	**Endocrine**		
Hearing Loss	yes	no	**Respiratory**			Excessive Thirst	yes	no
Itching in Ears	yes	no	Shortness of Breath	yes	no	Heat/Cold Intolerance	yes	no
Ringing in Ears	yes	no	Cough	yes	no	**Psychiatric**		
Nose			Wheezing	yes	no	Anxiety	yes	no
Bleeding from Nose	yes	no	**Gastrointestinal**			Depression	yes	no
Decreased sense of smell	yes	no	Nausea	yes	no	Panic Attack	yes	no
Nasal Congestion	yes	no	Heart Burn	yes	no	**Heme-Lymph**		
Nasal Discharge	yes	no	Ulcers	yes	no	Easy Bleeding	yes	no
Nasal Pain	yes	no	Diarrhea	yes	no	Bruising	yes	no
Snoring	yes	no				Anemia	yes	no
						Allergic/Immunologic		
						Food Sensitivities	yes	no
						Chemical Sensitivities	yes	no
						Seasonal Allergies	yes	no

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PATIENT AUTHORIZATION

In order to preserve confidentiality and comply with the Privacy Rule under the Health Insurance and Portability Act of 1996, it is important that we have an authorization from you before we discuss your condition or your account information (this information is considered Protected Health Information (PHI) to a person other than yourself or your legal guardian.

PATIENT NAME _____

Persons to whom PHI may be released:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Patient Signature _____ **Date** _____

Due to the Privacy Rule, it may be necessary to contact you at home. Please indicate below whether we have your approval to contact you regarding:

Appointments Test Results Prescriptions Billing Questions

Do we have your permission to leave a message on your voicemail or with a family member at your residence: Yes _____ No _____

Patient Signature _____ **Date** _____