

Seal Rheney Melvin
Moore Currens Lane
Robertson Shields

Asheville Head Neck & Ear Surgeons, PA MEDICAL HISTORY

ID# _____
(For Office Use Only)

Date: _____ Home Phone: () - _____
Patient Name: _____ Age: _____ Birthdate: / /
Referring Physician: _____ Family Physician: _____
Brief reason for today's visit: _____ Accident Date: / /

Smoke YES NO Packs per day _____
- Number of years _____ Year stopped if past smoker _____
- If child, does anyone in the household smoke? YES NO
Chew/Dip YES NO
Alcohol YES NO Drinks per day _____
Pregnant YES NO
Children YES NO How Many? _____
Married YES NO Divorced? YES NO
- If child, do they live with parent or other? _____
Recreational drugs YES NO

List Past Surgeries: (name and year of surgery)

Past Medical History: Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance. **Circle yes or no for each item.** Thank you.

Cardiovascular

YES NO Heart attack
YES NO Heart failure
YES NO High blood pressure
YES NO Circulation problems
YES NO High Cholesterol

Pulmonary

YES NO Asthma
YES NO Emphysema
YES NO Sleep apnea
YES NO C pap machine
YES NO Pulmonary embolus

Urinary

YES NO Kidney stones
YES NO Prostate problems

Orthopedic

YES NO Arthritis

Endocrine

YES NO Diabetes
YES NO Thyroid disease

Skin

YES NO Eczema
YES NO History of skin cancer

Neurologic

YES NO Stroke / CVA
YES NO Seizures
YES NO Glaucoma

Allergy/Immunology

YES NO Hepatitis A, B, C
YES NO TB (tuberculosis)
YES NO HIV/AIDS
YES NO CMV virus
YES NO Current Immunizations
YES NO MRSA

Intestinal

YES NO Stomach / ulcers
YES NO Jaundice
YES NO GERD

Hematology / Lymphatic

YES NO History of blood clots or DVT
YES NO Lymphoma
YES NO Bleeding disorder

Other Medical Problems:

Cancer

YES NO Thyroid cancer
YES NO Head & neck cancer
YES NO Other: _____

Family History: Please specify which member of your family (mother, father, sister, brother, grandparents) have had the following medical problems.

YES NO Cancer (what kind) _____ YES NO Reactions to Anesthesia _____
YES NO High blood pressure _____ YES NO Diabetes _____
YES NO Heart attack _____ YES NO Hearing loss _____
YES NO Bleeding problems _____ YES NO Other diseases _____

Form completed by: _____ Signature: _____

→ → → → **OVER** → → → →

List Medications: (include those you buy without a prescription, include vitamins & natural products):

List Medication Allergies: (list reactions)

PHARMACY INFORMATION Please provide at least the name and approximate location for prescription purposes.

Name: _____ Phone Number: () - _____
 Address: _____ Fax Number: () - _____
 City: _____ State: _____ Zip Code: _____

Current Symptoms: Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance. **Circle yes or no for each item.** Thank you.

<u>Ear</u>		<u>Endocrine</u>		<u>Urinary</u>	
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO		
YES	NO	YES	NO	YES	NO
		YES	NO	YES	NO
		YES	NO		
<u>Nose</u>		<u>Pulmonary</u>		<u>Orthopedic</u>	
YES	NO	YES	NO	YES	NO
		YES	NO	YES	NO
		YES	NO	YES	NO
		YES	NO		
		YES	NO		
<u>Throat</u>		<u>Skin</u>		<u>Neurologic</u>	
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
		YES	NO	YES	NO
<u>Cardiovascular</u>		<u>Intestinal</u>		<u>Hematology / Lymphatic</u>	
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
YES	NO	YES	NO	YES	NO
		YES	NO		
<u>Eyes</u>		<u>Constitutional</u>			
YES	NO	YES	NO		
YES	NO	YES	NO		
		YES	NO		
		YES	NO		
<u>Allergy/Immunology</u>					
YES	NO				
YES	NO				
YES	NO				
YES	NO				

Other Current Symptoms: _____

Thank you for choosing our practice for your health care. In order to assist you in understanding and managing your responsibilities as a patient in our office, we have developed a financial policy, as well as, some general office policies which will help prevent unnecessary increases in your medical bills. Please read and sign this policy prior to your visit with our physician.

1. Our office requires that you fully complete a patient information form, which includes all current insurance information for the patient prior to being seen in our office.
2. **Payment in full is expected at the time of service.** We accept personal checks, cash, Visa and Mastercard. **AHNE will expect full payment of copays, coinsurance and deductibles at the time of service if your visit is covered by an insurance plan with which we participate.** Currently those plans include Medicare, Medicaid, NC Health Choice for Children, NC Blue Cross Blue Shield products, Encompass, Medcost, Primary Physician Care, Cigna and the WNC Health Coalition. **Non-emergent visits will be rescheduled if you are unable to pay the copayment or coinsurance at the time of the visit.**
3. Insurance claims: Office visits: AHNE will file claims with all insurance companies though we will collect payment in full at the time of service if we do not participate with your insurance.
Surgeries: AHNE will file claims with all insurance companies for surgical claims. Any noncovered surgical expenses must be paid in full at the time of service or prior to the surgery. **Copayments and deductibles will be collected prior to surgery.**
4. If you have unique financial problems, please discuss them with us. Payment will be expected within 10 days of the receipt of the statement.
5. Please be advised that AHNE works with a professional collection agency and any unpaid accounts will be given to this agency for collection efforts. This would effect your credit rating and show on your credit report.
6. Please understand that your insurance coverage is a contract between you, your employer and your insurance company. You are responsible for any balance not paid by your insurance company in 60 days for the date of services.
7. The adult parent or guardian accompanying a minor to our office will be regarded as responsible for all balances and transactions for the patient. We will not serve as an intermediary. **Unaccompanied minors will not be seen in our office except on an emergency basis.**
8. Medicaid patients must present a current Medicaid card at the time of their visit. Adults will also be expected to have their \$3.00 copayment at the time of their visit. **Your appointment will be rescheduled if you do not present a current Medicaid card and pay your copay.**
9. A physician is always on call for emergency care for our office. Please limit requests for appointments and prescription refills to our regular office hours between 9AM and 5PM. After hours calls will be answered by our answering service who will have a physician return your call.
10. Failure to uphold the terms of these policies may result in dismissal from AHNE.
11. Comments: _____

I have read and understand this financial policy. I accept the terms of the policy.

Signature: _____ **Date:** _____