Greenwood Ear Nose and Throat Specialists
Erika Almeida-Trujillo, DNP
Office: (719)544-7115
Fax: (719)544-6242

PATIENT PROFILE

(Please print or write legibly)

First Name: _____ Last Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Marital Status: _____ Last 4 of SS#: _____

Race (circle one): White Black/AfricanAmerican Asian American Indian Pacific Islander European

Primary Care Doctor: _____ Referring Doctor: _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

E-Mail Address: _____

If the patient is a **Minor** or **Student**:

Mother's Name: _____ DOB: _____ Last 4 or SS: _____

Father's Name: _____ DOB: _____ Last 4 of SS: _____

Is the patient the guarantor of the insurance policy or financially responsible for their care? ____Yes ____No If no, please provide guarantor information below:

Insured's Name: _____ **DOB:** _____ **Relationship:** _____

Phone: _____ **Last 4 of SS:** _____

Employer: _____ **Address:** _____ **Phone:** _____

Preferred Pharmacy: _____ Address: _____

Authorization: I hereby authorize the provider indicated above to furnish information to my health insurance and assign to the provider all payments for medical services rendered. I understand that I am financially responsible for all charges after insurance processes claims and for any reasonable collection and attorney/court costs associated if account is sent to collections.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Name: _____

Financial Policies

1. Commercial insurance: You are responsible for deductibles, copays, coinsurances, any non-covered services including out-of-network charges specific to your plan. Copays are due at time of service and balances are due 30 days after receipt of payment from your insurance company.
2. Private pay: Payment is due at time of service. A 15% prompt pay discount will be given at time of service.
3. Medicare: We will submit charges to Medicare and any supplemental insurance if applicable. You are responsible for copays, coinsurances and any non-covered services.
4. Medicaid: We will submit charges to Medicaid; you will be responsible for copays.

Guarantee of payment

1. I understand that I am responsible for payment of all fees and services rendered after insurance has processed claims. **NOTE:** We will bill your primary insurance; if they do not pay in a timely manner (within 90 days from the date of service and filing) the insured will be expected to pay the balance and then pursue reimbursement from the insurance company. There will be a $30 fee for any returned check for NSF.
2. I have been advised that if my commercial insurance/Medicare/Medicaid plan claims that the services I receive from Greenwood Ear Nose and Throat Specialists are not considered reasonable and medically necessary for my care that I will be responsible for the payment of these services.
3. I understand that my insurance **MAY** require a referral from my primary care provider and if proper authorization is not obtained in advance, my insurance may deny payment and I will be responsible for payment of all services.
4. I understand that it is my responsibility to make sure that Greenwood Ear Nose and Throat is a network provider for my specific insurance plan even if I have been advised that we are contracted with the plan. I understand that I may be responsible for paying out-of-network fees if relevant.

Assignment

1. I assign the benefits from my insurance carriers to this office for the medical benefits to which I am entitled.
2. I request that payment of authorized Medicare benefits be made on my behalf to Greenwood Ear Nose and Throat Specialists for any service furnished to me by these providers.

Release of Information

1. I authorize Greenwood ENT to release to my insurance carrier any information needed to determine benefits payable for services.
2. I authorize Greenwood ENT to release any information regarding my evaluation and treatment to my referring/primary care providers.
3. I authorize any physician, hospital, laboratory or radiology facility to release to Greenwood ENT any and all medical information, hospital records, lab studies or x-rays that may be requested.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

_____(initial) **I have read and understand the Greenwood ENT Financial & Privacy Policies.**

I authorize Greenwood ENT to discuss my private health information with the following persons:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

_____ _____
Signature **Date**

_____ _____
Signature of Patient's Representative **Relationship**

Greenwood Ear Nose and Throat Specialists

Patient name: _____ Date of Birth: _____

Review of Systems

What is your height? _____ What is your weight? _____

Pregnant Y N
Fatigue Y N
Fever or chills Y N
Weight loss Y N

Eyes
Blurred vision Y N
Double vision Y N
Eye Pain Y N
Red Eyes Y N
Dry Eyes Y N
Other _____

Ears
Difficulty hearing Y N
Sensitivity to loud noises Y N
Ear Pain Y N
Tinnitus (ringing in ears) Y N
Pressure in ears Y N
Discharge from ears Y N
Other _____

Mouth/Throat
Bleeding gums Y N
Dry Mouth Y N
Mouth Ulcer Y N
Bad Breath Y N
Snoring Y N
Sore throat Y N
Hoarseness Y N
Lump in throat Y N
Constantly clearing throat Y N
Other _____

Neurologic
Frequent headaches Y N
Seizures Y N
Numbness Y N
Weakness Y N
Dizziness (vertigo) Y N
Lightheadedness Y N
Memory loss or lapses Y N
Decreased sense of smell Y N
Loss of taste Y N
Loss of balance Y N
Restless legs Y N

Cardiovascular
Chest pain Y N
History of murmur Y N
Difficulty breathing Y N
Palpitations Y N
Edema Y N
Other _____

Respiratory
Wheezing Y N
Shortness of breath Y N
Hemoptysis (coughing blood) Y N
Sleep Apnea Y N
Other _____

GI
Vomiting Y N
Heartburn Y N
Painful swallowing Y N
Difficulty swallowing Y N
Loss of appetite Y N
Abdominal pain Y N
Jaundice Y N
Diarrhea Y N
Constipation Y N
Other _____

Hematologic/Lymphatic
Swollen glands Y N
Bruises easily Y N
Excessive bleeding Y N
Other _____

Integumentary
Rash Y N
Itching Y N
Dry skin Y N
Growths/Lesions Y N

Allergic/Immunologic
Frequent sneezing Y N
Runny Nose Y N
Nasal itching Y N
Eye itching Y N

Endocrine
Intolerance to Cold Y N
Intolerance to Heat Y N
Other _____

Greenwood Ear Nose and Throat Specialists

Patient Name: _____ Date of Birth: _____
What brings you in to see us: _____
How long have you had this problem: _____

Allergies to medications, latex or foods; write n/a if no allergies.

_____

_____

Past Medical History (check all that apply):

___ Anemia ___ Cancer ___ Fibromyalgia ___ Hypertension ___ Stroke
___ Asthma ___ COPD ___ Heart disease ___ Kidney disease ___ Thyroid problems
___ Diabetes ___ High cholesterol ___ Liver disease ___ Bleeding disorders
___ Emphysema ___ Hyperlipidemia ___ Sleep disorders Other: _____

Social History (circle yes or no):

Do you smoke or vape Yes No # of packs a day_____ # of years _____ Quit date _____
Do you chew tobacco Yes No # of years _____ Quit date _____
Do you use marijuana Yes No # of years _____ Quit date _____
Do you drink alcohol Yes No # of drinks per week _____
Do you use caffeine Yes No # of cups per day_____
Do you take opiods (Percocet, Norco, etc.) Yes No # of years _____

Family History (check all that apply):

___ Allergies ___ Cancer-type _____ ___ Hearing loss ___ Strokes
___ Asthma ___ Diabetes ___ Heart disease ___ Thyroid
___ Bleeding disorders ___ Hypertension Other: _____

Surgical History – Surgery and Year Performed (check all that apply and add year):

___ Adenoidectomy_____ ___Inner Ear Surgery_____ ___Tonsillectomy _____
___Appendectomy_____ ___Middle Ear Surgery_____ ___Cardiac surgery_____
___Nasal septum_____ ___Ear Tubes_____ ___Neck surgery_____
___Esophagus surgery_____ ___Nose surgery_____
___External ear surgery_____ ___Salivary gland surgery_____
___Eye surgery_____ ___Sinus surgery_____
___Facial cosmetic surgery_____ ___Throat surgery_____
Other surgeries: _____

Medications and supplements (if you need more space, write on the back and write "continue") Please write n/a if not taking any medications.

_____ _____

_____ _____

_____ _____