Massachusetts E.N.T. Associates
Medical History Form

Date of visit: _______________

Name:________________________________**Address**____**D.O.B.:**_____________________
Phone (Work/Home):____
Name and address of Primary Care Physician:____
Name and address of Physician requesting consult:____
Primary Reason for this office visit:____
____
____
____
____
Major Medical Illness/Previous Operations:____
____
____
Current Medications (Including Aspirin/Herbal medicines/Over the counter medications:_______________________________
____
Allergies (Medications or environmental):____
____
Family History (e.g. Easy bleeding):____
Social History: Have you ever smoked?________**How long?**_______________**How much?**___________________**When quit?**__________
Alcoholic beverages per day:__________________________________
Occupation:____**Hobbies:**__________________________

Review of Systems:
Do YOU have a history of:

	Yes	No
Hearing loss		
Tinnitus/Ringing in ears		
Ear pain		
Ear drainage		
Dizziness/vertigo		
Sensation of blocked ears		
Facial weakness		
Previous ear surgery		
Exposure to loud noises		
Family history of hearing loss		
Nasal congestion/obstruction		
Nasal discharge		
Post nasal drip		
Nose bleeds		
Loss of smell		
Nasal polyps		
Concern about nasal appearance		
Sinus problems		
Abnormal sinus Xrays		
Facial pain or headaches		
Recurrent sore throats		
Trouble or pain with swallowing		
Hoarseness		
Neck swelling/mass/infection		
Head and Neck cancer/tumor		
Previous ENT surgery		
Positive allergy skin tests		
Poor vision or double vision		
Other visual problems		
Second hand smoke exposure		

	Yes	No
Heart disease		
Chest pain/pressure		
High blood pressure		
Heart murmur/mitral valve prolapse		
Lung disease		
Shortness of breath		
Wheezing/asthma		
Cough		
Tuberculosis infection (T.B.)		
Ulcer disease		
Heartburn/indigestion		
Diarrhea/constipation		
Liver disease/hepatitis/cirrhosis		
Kidney disease		
Kidney stones/bloody urine		
Neurologic disease/seizures		
Strokes/numbness/paralysis		
Easy bruising or anemia		
Cancer/tumor		
HIV infection		
Diabetes		
Thyroid mass/problems		
Fevers/unexplained weight loss		
Use of recreational drugs		
Depression		
Psychiatric problem		
Skin conditions/Skin cancer		
Joint disease/muscle weakness		
Are you pregnant		
Other pertinent issues		

Insurance Information Sheet

To avoid delays in processing claims, please provide the following information:

Patient name:____

Referring doctor:____

Patient's Social Security Number:______________________________________

Primary Insurance Information

Insurance carrier:____

Subscriber name:____

Relationship to patient (circle one): self spouse father mother child

Subscriber social security number:_____________________________________

Subscriber date of birth:____

Subscriber employer:____

Secondary Insurance Information

Insurance carrier:____

Subscriber name:____

Relationship to patient (circle one): self spouse father mother child

Subscriber social security number:_____________________________________

Subscriber date of birth:____

Subscriber employer:____

Massachusetts Ear, Nose, and Throat Associates
3 Meeting House Road
Chelmsford, MA 01824
(978)-256-5557 (Office)
(978)-256-1835 (Fax)

Our Financial Policy

We are committed to providing you with best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **You must have your insurance card with you for each appointment.**

- **For patients with insurance with which we are participating/contracted with :**
  Copayments, deductibles, and co-insurance amounts are due at the time of service.

- **Patients with non-participating/contracted insurances:**
  Full payment is expected at the time of service.

- **Patients with insurance that requires a referral from a Primary Care Physician:**
  Referral must be in place on the date of service. Without this referral in place, full payment or rescheduling would be required.

- **We accept cash, personal checks, Visa, and MasterCard**

- **Non-emergency treatment will be denied if:**
  A minor under eighteen is unaccompanied by an adult.
  A patient with Medicaid coverage does not have a valid MASS HEALTH insurance card.
  A "referral" is not obtainable when required by the patient's insurance.
  A patient has been delinquent on back payments and/or the account has been sent to our "Collection" agent.
  A patient has missed more than three previous appointments and has been advised of being denied another appointment.

I hereby authorize Mass E.N.T. Associates to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company and/or attorney, from PIP benefits or settlement proceeds, be made to Mass E.N.T. Associates.

I permit a copy of this form to be used in the place of the original.

I,____, have read and understand the conditions For payment to the Mass. E.N.T. Associates as outlined above. Date:______________________________

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

Signature ____ Date:______________________________

Massachusetts Ear, Nose and Throat Associates, Inc.

HIPAA

I acknowledge having received a copy of the practice's Notice of Privacy Practices

Signature____ Date ___________________

Print your name ____