RUBY VALLEY EAR, NOSE THROAT & ALLERGY
PATIENT INTAKE FORM

PATIENT INFORMATION:

Last Name: _____ MI: ___ First Name: _____
Date of Birth: _____ Gender: _____ Age: _____
Mailing Address: _____
Home Phone: _____Cell Phone:_____
I prefer reminders via: ☐ Text ☐ Voice
Employer: _____ Employer Phone: _____
Preferred Pharmacy: _____ Primary Care Provider: _____
Referring Provider: _____ Patient Height: _____ Patient Weight: _____

PRIMARY INSURANCE:

Insurance Name: _____ Insurance Phone #: _____
Policy #: _____ Group #: _____ Relationship:_____
Policy Holders Name: _____ DOB:_____
Employer: _____ SS#_____

SECONDARY INSURANCE:

Insurance Name: _____ Insurance Phone #: _____
Policy #: _____ Group #: _____ Relationship:_____
Policy Holders Name:_____ DOB:_____
Employer: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Date of Birth: _____SS#:_____
Address: _____
Phone: _____ Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION:

Contact Name:_____ Relationship: _____
Phone: _____

HEALTH INFORMATION USES AND DISCLOSURES AUTHORIZATION/HIPPA POLICY:

I have read or received a copy of Notice of Privacy Practices/Health Insurance Portability & Accountability Act (HIPPA) policy of Ruby Valley Ear, Nose Throat & Allergy ("Ruby Valley ENT") (see attached document on clipboard; a copy will be provided at patient's request). I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to myself or child during the period of such care, to third party payers and other health practitioners.

ACKNOWLEDGMENT OF PAYMENT RESPONSIBILITY AND COLLECTION FEE NOTICE

I unconditionally acknowledge, understand, accept, and agree to all of the following:

1. My insurance carrier may not pay all of, or deny payment for, services. I am and shall be personally responsible for payment of all services rendered to me.

2. If I do not pay my account with Ruby Valley ENT, it may be assigned to a collection agency for collection. If my account is assigned to a collection agency, such agency will charge a commission or fee in addition to the amount I owe to Ruby Valley ENT. If my account is assigned to a collection agency, Ruby Valley ENT will add the amount of the collection agency's commission or fee to the amount I owe Ruby Valley ENT. I shall pay that additional amount.

3. In the event that legal action is commenced to enforce my obligations hereunder, I shall pay court costs and reasonable attorney's fees. This new patient intake form is governed by the laws of the State of Nevada and the venue is and shall be in Elko County, Nevada.

MINOR PATIENT/PARENT/GUARDIAN/GUARANTOR INFORMATION:

(If the patient is a minor, the parent or legal guardian accompanying the minor to Ruby Valley ENT is the Guarantor and must complete this section)

I understand that my insurance carrier may not pay all of, or deny payment for, services. I unconditionally acknowledge, understand, accept, and agree that I will be responsible, and guarantee payment as Guarantor, for such amounts and any and all amounts incurred by my dependant/s for services rendered by Ruby Valley ENT. In the case of default in payment of this account, I agree to pay and guarantee payment, as Guarantor, of collection costs and reasonable attorney fees involved in the attempt to collect account balances.

Name: _____ Date of Birth: _____SS#:_____
Address: _____
Phone: _____ Relationship to Patient: _____

_____ _____
Signature of Guarantor Date

NO-SHOW APPOINTMENT POLICY

At Ruby Valley ENT our goal is to provide quality individualized care in a timely manner. Appointment times are very important to our patients, especially those who have to wait to see the Doctor because of a booked time slot. A "No-show" is when a patient fails to call or show up for a scheduled appointment. Such persons will be charged a $20.00 No-Show Fee. While we are trying to eliminate "No-Shows" we are in no way trying to make money from them. Accordingly, and at the end of every year we will donate any and all of those fees to a local charity. There will also be a $25.00 returned check fee. Thank you for understanding and efforts to come and see us. We look forward to serving you.

I have read and understand all the information on this Patient Intake Form and unconditionally agree to all of its terms and conditions. I have completed the above answers and certify that the information is true and correct to the best of my knowledge and I hereby give Ruby Valley ENT permission to treat my concerns. I understand that this consent will be valid and remain in effect as long as I receive services from Ruby Valley ENT.

_____ _____
Signature of Patient/Parent/Guardian (circle one) Date

PATIENT HISTORY

Name: _____ DOB: _____ Gender:_____
Reason for your visit:_____ Duration of Symptoms: _____
Have you had any lab tests, hearing screens, or diagnostic imaging done relating to these problems? ☐ YES ☐ NO
If yes, what and where? _____
List all medications (include vitamins & herbs): _____
_____
_____
_____
Do you have any allergies to medications? _____

PAST MEDICAL HISTORY: (Please check all that apply)
☐ Hypertension ☐ Heart Disease ☐ COPD ☐Asthma ☐ Liver Disease ☐ Stroke if so date: _____
☐Seizure Disorder ☐ Cancer: _____ ☐ Other: _____

SURGICAL HISTORY: _____
_____
_____

FAMILY HISTORY: Father: Age _____ ☐ Deceased Mother: Age _____ ☐ Deceased

SOCIAL HISTORY:
Alcohol Use: ☐ Non-Drinker ☐ Occasional ☐ Moderate ☐ Heavy
Caffeine Use: ☐ Non-User ☐_____ounces/day
Tobacco Use: ☐ Non-User ☐_____packs or cans/day for _____ years ☐ Previous User
Are you or could you be pregnant? ☐ NO ☐ YES Are you currently breast-feeding? ☐ NO ☐ YES

REVIEW OF SYSTEMS: (Please check symptoms pertaining to your current problem)

ALLERGY:☐ Runny Nose ☐ Scratchy Throat ☐ Itchy Eyes ☐ Ear Fullness ☐ Sinus Pressure ☐ Nasal Congestion
RESPIRATION: ☐ Shortness of Breath ☐ Chest Tightness ☐ Cough ☐ Wheezing
CARDIOLOGY: ☐ Chest Pain ☐ Palpitations ☐ Leg Edema ☐ Shortness of Breath ☐ High Blood Pressure
GENERAL: ☐ Weight Gain ☐ Loss of Appetite ☐ Fever ☐ Weakness ☐ Weight Loss ☐ Fatigue ☐ Chills
DERMATOLOGY: ☐ Rash ☐ Hives ☐ Scaly Skin ☐ Eczema
ENDOCRINOLOGY: ☐ Fatigue ☐ Increased Thirstiness ☐ Increased Urination ☐ Sleep Disturbance
☐ Cold/Heat Intolerance
OTOLARYNGOLOGY: ☐ Nose Bleeds ☐ Hearing Loss ☐ Hoarseness ☐ Sore Throat ☐ Ear Ringing ☐ Dizziness
☐ Snoring ☐ Facial Pressure ☐ Noise Exposure ☐ Ear Pressure ☐ Postnasal Drainage ☐ Frontal Headaches
GASTROENTEROLOGY: ☐ Nausea ☐ Heartburn ☐ Acid Reflux ☐ Vomiting ☐ Difficultly Swallowing
☐ Abdominal Pain ☐ Diarrhea ☐ Constipation
HEMATOLOGY/LYMPHATIC: ☐ Easily Bruised ☐ Anemia
MUSCULOSKELETAL: ☐ Joint Stiffness ☐ Joint Pain ☐ Osteoporosis Treatment ☐Back Pain
NEUROLOGY: ☐ Headache ☐ Seizures ☐ Insomnia ☐ Dizziness ☐ Head Injuries
OPHTHALMOLOGY: ☐ Eye Irritation ☐ Eye Pain ☐ Eye Drainage ☐ Blurry Vision ☐ Double Vision
PSYCHOLOGY: ☐ Depression ☐ Increased Stress Levels ☐ Suicidal Thoughts ☐ Eating Disorders ☐ Anxiety
UROLOGY: ☐ Frequent Urination ☐ Blood in Urine ☐ Incontinence ☐ Recurrent UTI ☐ Loss of Urinary Control

I certify that the information I am providing is correct and accurate to the best of my knowledge.

_____ _____
Signature of Patient/Parent/Guardian/Authorized Representative Date