ALABAMA
EAR, NOSE & THROAT
SPECIALISTS, LLC

Craig M. Benoit, MD **Gordon A. Shields, MD** **Susanne M. Snider, CRNP**

PATIENT INFORMATION **DATE:** _____

Name: _____ **Gender:** ☐ Male ☐ Female
Last First Middle (Circle One)

Date of Birth: _____ **Age:** _____ **Patient's SS#:** _____

Address: _____
Street Address Apt # City State Zip Code

Name of Employer: _____ **Phone:** _____

Home Phone: _____ **Cell:** _____

Email: _____ **Marital Status:** ☐ ☐ ☐ ☐ **S / M / D / W (circle one)**

Parent or Guardian's Name (for minors): _____ **DOB**_____ **SSN** _____

Referring Dr: _____ **Primary Dr:** _____
(First & Last Name) (First & Last Name)

Is this visit a result of accident/injury? ☐ Yes ☐ No If "Yes", when and where did it occur?

_____

Pharmacy: _____
Name Street City Phone Number

How did you find us? Physician_____ Hospital _____ Friend _____
☐ Website _____ ☐ Advertisement (type) _____ Other _____

INSURANCE INFORMATION

Please have insurance card & driver's license available at time of appointment. It is necessary to have accurate information to file your claim. If information provided below is incorrect or incomplete you will be financially responsible for all charges rendered.

Primary Insurnce Company: _____ **Employer:** _____

Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Policy/ID #: _____ **Group #:** _____ **Policy Holder's Name:** _____

Policy Holder's DOB: _____ **Policy Holder's SS#:** _____

Secondary Insurance Company: _____ **Employer:** _____

Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Policy/ID #: _____ **Group #:** _____ **Policy Holder's Name:** _____

Policy Holder's DOB: _____ **Policy Holder's SS#:** _____

New Patient Info

302 Merchants Walk, Suite 100, Tuscaloosa, AL 35406 *Phone:* (205) 523-9300 *Fax:* (205) 523-9301
www.alabamaentspecialists.com

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PATIENT MEDICAL HISTORY

Patient's Name: _____

Reason for today's visit: _____

List your medications and dosage _____

_____

_____

_____

Drug allergies: _____

Prior Surgeries:

_____

_____

Prior Radiation: ☐ Yes ☐ No Prior Chemotherapy ☐ Yes ☐ No

Please Check the Appropriate Boxes if Applicable

PATIENT HISTORY	Past	Current	FAMILY HISTORY	Mother	Father	Brother	Sister
Allergic rhinitis			Allergic rhinitis				
Anxiety			Anxiety				
Asthma			Asthma				
Heart Condition			Heart Condition				
Lung Disease			Lung Disease				
Diabetes			Diabetes				
Hearing Loss			Hearing Loss				
Heartburn/Reflux			Heartburn/Reflux				
High Blood Pressure			High Blood Pressure				
Sleep Apnea/Snoring			Sleep Apnea/Snoring				
Kidney Failure			Kidney Failure				
Sinusitis			Sinusitis				
Stroke			Stroke				
Smoking			Smoking				
Anemia			Anemia				
Depression			Depression				
Heart Attack			Heart Attack				
Hypothyroidism			Hypothyroidism				
Migraine			Migraine				
Cancer (Type_____)			Cancer (Type_____)				
Other _____			Other_____				

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Do you use: Cigarette/Pipe/Cigar/Dip/Chew? ☐ Yes ☐ No How much? _____ For how long? _____

Are you still using? ☐ Yes ☐ No Former user? ☐ Yes ☐ No When did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No How much? _____ How often? _____

Have you ever used illegal drugs or IV drugs? ☐ Yes ☐ No What drugs? _____

Please circle the appropriate boxes if you are experiencing any of the following symptoms:

GENERAL
☐ Fever/Chills ☐ Body Aches ☐ Unexplained Weight Loss

EYES
☐ Watery ☐ Itchy ☐ Blurring ☐ Double Vision

EAR, NOSE, THROAT
☐ Ear Pain ☐ Hearing Loss/Ringing ☐ Dizzy ☐ Stuffy Nose ☐ Runny Nose ☐ Hoarseness ☐ Sore Throat ☐ Trouble Swallowing

CARDIOVASCULAR
☐ Chest Pain ☐ Palpitations ☐ Fainting

RESPIRATORY
☐ Cough ☐ Shortness of Breath ☐ Wheezing

GASTROINTESTINAL
☐ Nausea ☐ Vomiting ☐ Diarrhea

MUSCULOSKELETAL
☐ Joint Pain ☐ Joint Swelling ☐ Muscle Cramps

SKIN
☐ Eczema ☐ Rashes ☐ Suspicious Lesions

NEUROLOGIC
☐ Paralysis ☐ Numbness ☐ Seizures

HEMELYMPHATIC
☐ Abnormal Bruising ☐ Abnormal Bleeding ☐ Enlarged Lymph Nodes

ALLERGIC/IMMUNE
☐ Nasal Allergies ☐ Allergic Dermatitis ☐ Recurring Infections

Patient's Signature: _____ **Date:** _____

New Patient Medical Hx

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ASSIGNMENT OF BENEFIT AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Alabama Ear, Nose & Throat Specialists, LLC (ALENTS) for medical or surgical services or items rendered to me or my dependent by ALENTS. Should my insurance carrier deny ALENTS, I understand that I am financially responsible for the charges. I authorize ALENTS to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. Should failure to pay for medical services result in my account being turned over for collection from a third party, or my insurer, I understand that I am responsible for the account balance plus reasonable collection and/or attorney's fees. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Patient or Legal Guardian: _____
Print

Signature _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

You have been given the Notice of Privacy Practices for Alabama Ear, Nose & Throat Specialists, LLC (AENTS) and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of AENTS with respect to health information created for services generated by AENTS. If you receive services by your physician or other health care providers at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicates that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call our Practice Administrator at (205) 523-9300.

Patient Name: _____ Date: _____

Signature of Patient or Responsible Party: _____

PERSONAL HEALTH INFORMATION

I authorize ALENTS and medical staff to discuss my healthcare information *(which may include history, diagnosis, labs, test results, treatments and other health information)* with the contacts listed below.

I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want my information released to anyone else.

PERSONAL HEALTH INFORMATION CONTACTS:

Name: _____ Relationship to Patient: _____

Contact Info: _____

Name: _____ Relationship to Patient: _____

Contact Info: _____

Name: _____ Relationship to Patient: _____

Contact Info: _____

EMERGENCY CONTACT ONLY:

Name: _____ Phone: _____

PHONE NUMBERS: At which phone numbers would you like to receive calls about appointment, financial or medical condition information? ***[check all that apply]***

☐ Home Phone ☐ Cell phone ☐ Work Phone ☐ Other Phone:

VOICE MAIL: May appointment, financial or medical information be left on your answering machine or voice mail? ☐ Yes ☐ No

EMAIL: When responding to an Email, may we include appointment, financial or medical condition information? ☐ Yes ☐ No

_____

Patient Signature

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Thank you for choosing Alabama Ear, Nose & Throat Specialists.

In order to track Meaningful Use of our Electronic Medical Record, we are required to maintain the information below as part of your personal medical record.

As with all of your medical information, this will be maintained CONFIDENTIALLY.

Patient Name: _____

Email Address: _____@_____

*We will grant you access to our patient portal for electronic messaging and access to portions of your health record. We will NOT share your email address with any other parties.

Primary Language: (Check One)

☐ ENGLISH
☐ SPANISH
☐ INDIAN (Includes Hindi & Tamil)
☐ RUSSIAN
☐ OTHER: _____

Race: (Check One)

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Hispanic
☐ Other Race
☐ Unreported / Prefer Not to Answer

Ethnicity: (Check One)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Answer

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