South Seattle Otolaryngology, a Division of Proliance Surgeons Inc PS

Patient Name: _____ _____
First Middle Last Suffix

Birthdate: _____ _____ Age: ___ _____ SS#: _____ Gender: _____

PLEASE PROVIDE PO BOX AND HOME ADDRESS

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Home Phone#: _____ Day/ Work/Cell Phone #: _____

(If Minor, PARENT INFORMATION)

Name: _____ Relationship: _____ Phone: _____

Employer Name: _____ City: _____ State: _____

Occupation: _____

Referred By: _____ M.D. PCP/ Other: _____

Emergency Contact: _____ Phone #: _____

PAYMENT IN FULL IS DUE AT TIME OF SERVICE UNLESS INSURANCE CARD(S) PROVIDED

Primary Insurance Subscriber Information

Subscriber Name: _____
Relation to Patient: _____
Insurance Co Name: _____
Subscriber ID#: _____ DOB: _____
Subscriber Group: _____

Secondary Insurance Subscriber Information

Subscriber Name: _____
Relation to Patient: _____
InsuranCo Name: _____
Subscriber ID#: _____ DOB: _____
Subscriber Group: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By my signature below I acknowledge receipt of South Seattle Otolaryngology,a division of Proliance Surgeons Inc PS Privacy Practices

_____ _____ _____
Signature Relationship to Patient Date

Assignment Release & Financial Agreement: I authorize treatment of the above named person and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for the non-covered services. I also authorize the physicians to release any information requested. I understand that my insurance may deny payment for any reason including but not limted to the following: services not authorized by Primary Care Provider, services not authorized/covered by insurance co., referral from PCP's office at specialist office at time of appointment. I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency. I also understand that any unpaid patient balances over 60 days are subject to late fees.

South Seattle Otolaryngology is pleased to now offer patients professional services by electronic means - Telephone and Fax. Request for Dr. McClean, Dr. Green and Dr. Maurice may be made by telephone or fax.

These services are subject at a $15.00 minimum charge and are otherwise prorated at an hourly rate of. You will be notified prior to a service being rendered if a charge of more than $100.00 is anticipated. These charges do not apply to postoperative patient for 90 days post surgery, but otherwise are the responsibility of the patient. As a courtesy we now accept credit card payments (Visa/MC).

Missed Appointments/Cancellations

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. A fee will be charged associated with missed or late-canceled appointments. A $40.00 fee will be applied for all missed or late-canceled appointments.

***** Any unpaid balance over 60 days are subjected to late fees ****

_____ _____/_____/_____
Patient Signature or Legal Guardian DOB Date

South Seattle Otolaryngology
Head and Neck Surgery
16259 Sylvester Road S.W.
Suite 505
Seattle, Washington 98166
(206) 242-3696

Patrick H. McClean, M.D., F.A.C.S.
David C. Green, M.D., F.A.C.S.
Peter F. Maurice, M.D., F.A.C.S.

South Seattle Hearing Aids
Vanessa Rentschler, M.S., CCC-A
Billie Garber, M.S., CCC-A

Patient Chief Complaint

Patient Name:_____ Date of initial visit:___/___/___

Date of birth:___/___/___ Referring Physician:_____

Reason for today's visit?_____

When did the symptoms first begin?_____

Did anything specific cause the problem to begin?_____

What makes it better?_____ Worse?_____

PLEASE LIST ALL DRUG ALLERGIES:_____

Patient Health History

Please put an "X" if the patient is being treated for any of the following:

__Asthma
__Chest Pain/ Heart Attack
__Chronic Bronchitis
__Congestive Heart Failure
__Diabetes
__Emphysema
__High Blood Pressure
__Peptic Ulcers/ Gastritis
__Problems with Blood Clotting
__Thyroid Problems

Please list any prior hospitalizations or surgeries (include date, reason for hospitalization or surgery, surgery performed, and the hospital to which you were admitted).		
Current Medication(s)	**Dose**	**Frequency**

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Patient Name:_____ Date of Birth:____/____/____

Family History

Please circle one:

Family Member (in relationship to patient)	Alive	Deceased	Age	Health problems or Cause of death
Grandmother (Maternal)	A	D		
Grandfather (Maternal)	A	D		
Grandmother (Paternal)	A	D		
Grandfather (Paternal)	A	D		
Father	A	D		
Mother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		

Have you or a family member ever been diagnosed with a bleeding disorder? __Yes __No

If yes, please describe:_____

Social History (Fill out if patient is a Minor)

Who lives at home with your child? _____
Does your child attend school or daycare? ___ Yes ___ No
How many children are in the class? _____
Is your child exposed to cigarette smoke? ___ Yes ___ No
Is your child at risk for HIV or other blood-borne diseases? ___No ___Yes

If yes, please explain:_____

Social History (Fill out if patient is an Adult)

Occupation:_____
Marital Status: __Single __Married __Divorced __Widowed
Do You Have children: __Yes __No How many?_____
Do you live alone __Yes __No Who lives with you?_____
Do you smoke __Yes, I've smoked_____packs of cigarettes per day for_____years.
__Yes I smoke cigars or a pipe __Yes, I use smokeless tobacco __No, I've never smoked
No, I quit_____years ago. At that time I was smoking_____pack a day for_____years
Do you drink alcohol? __No, never (rarely) __No, but I used to
__Yes __Daily __1 or more times a week __1 or more times a month
Are you at risk for HIV or other blood-borne diseases? __No __Yes

If yes please explain_____

If you are female, When was the first day of your last menstrual period?_____/_____/_____

Patient Name:_____ Date of Birth:____/____/____

Review of Systems

Are you currently having problems with or being treated for the following?

General	*Circle One*	
Fever	Yes	No
Weight loss	Yes	No
Night Sweats	Yes	No

Skin		
Skin disease	Yes	No
Skin cancer	Yes	No

Eyes, Ears, Nose, Throat and Mouth		
Liver disease	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Wear hearing aids	Yes	No
Hearing loss	Yes	No
Ear pain	Yes	No
Ear infections	Yes	No
Ringing in ears	Yes	No
Balance disturbance	Yes	No
Nosebleeds	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Sinus headaches	Yes	No
Sore throats	Yes	No

Neck		
Neck Mass	Yes	No
Neck Pain	Yes	No
Neck Stiffness	Yes	No
Swollen Glands	Yes	No

Respiratory		
Chronic cough	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody sputum	Yes	No

Cardiovascular	*Circle One*	
Irregular pulse	Yes	No
Heart murmur	Yes	No
Swelling in feet	Yes	No
Leg pain	Yes	No

Gastrointestinal		
Indigestion or pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Jaundice	Yes	No
Colon cancer	Yes	No

Genitourinary		
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in urine	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No

Musculoskeletal		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Back pain	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No

Neurological		
Fainting spells or "blackouts"	Yes	No
Seizures	Yes	No
Problems with your memory	Yes	No
Disorientation	Yes	No
Difficulty with your speech	Yes	No
Double or blurred vision	Yes	No
Face weakness	Yes	No
Loss of coordination	Yes	No

Patient Name: _____ Date of Birth: ____/____/____

Review of Systems (continued)

Psychiatric	*Circle One*	
Anxiety	Yes	No
Depression	Yes	No
Other psychiatric Disorder/ treatment	Yes	No

Endocrine		
Increased appetite	Yes	No
Excessive thirst or urination	Yes	No
Hormone problems	Yes	No

Hematologic/ Lymphatic/ Allergic/ Immunologic	*Circle One*	
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding tendencies	Yes	No
Persistent swollen glands or lymph nodes	Yes	No
Blood transfusion	Yes	No
Food allergies	Yes	No
Inhalant (nasal) allergies	Yes	No

Rhinologic Facial pain/pressure/congestion/fullness, nasal congestion/obstruction, nasal discharge or purulence, post-nasal discharge/purulence, hyposmia/anosmia, headache, fever, halitosis, fatigue, dental pain, cough, ear pain/pressure/fullness, epistaxis

Sleep Apnea Snoring, stop-breathing spells, gasping, choking, daytime sleepiness (falling asleep driving, watching TV, as a passenger in a car, sitting, reading), daytime napping, car accident, morning headache, recent weight gain

Otologic Hearing loss, tinnitus (pulsatile), vertigo, aural fullness, family history of hearing loss, noise exposure, head and ear trauma, ototoxic meds, previous ear surgery

Oncologic Dysphonia, dysphagia, odynophagia, blood from the throat, otalgia, weight loss, fatigue, night sweats, fever

The above information is accurate to the best of my knowledge.

_____ _____

Patient or Parent/ Guardian Signature *Date*

I have reviewed the above information with the patient.

_____ _____

Physician Signature *Date*

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Authorization to Leave Personal Health Information

By Alternate Means

Patient Name: _____ **Date of Birth:** _____

Patient Mailing Address: _____

_____

(Please check all that apply)

- ☐ May leave detailed message on voicemail at home# :( ) _____
- ☐ May leave detailed message on voicemail at work # :( ) _____
- ☐ May leave information with spouse (name) : _____
- ☐ May leave information with other family member: _____
- ☐ May leave detailed message on cellular phone # :( ) _____
- ☐ May leave detailed message at a different location # :( ) _____
- ☐ May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____

Patient or legally authorized individual signature Date

PROLIANCE SURGEONS®

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Check one:

- ❑ **By my signature below I acknowledge receipt of the Notice of Privacy Practices.**
- ❑ **By my signature below I acknowledge that I have declined to accept the complete Notice of Privacy Practices and instead asked to receive only the Short Form Notice of Privacy Practices. I have been made aware that the complete Notice of Privacy Practices is available to me at any time, if I request a copy, is available and on display in the waiting room, and is available on the Proliance Surgeons wed site at address: www.proliancesurgeons.com.**

Patient or legally authorized individual signature	Date	Time
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)	

This area for staff notes (if any):

This form will be retained in your medical record.