Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ✓ ✗

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DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	☐	Metal	☐
Iodine	☐	Seafood	☐
Latex	☐	Contrast Dye	☐

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	☐	Gastrointestinal Reflux	☐
Lung Cancer	☐	Hepatitis	☐
Skin Cancer	☐	Stomach Ulcer	☐
Throat Cancer	☐		
Prostate Cancer	☐		
Other Cancer	☐	Are you pregnant?	☐
		Prostate Enlargement	☐
Migraine Headache	☐	Renal Failure	☐
Cataracts	☐	Stroke	☐
Glaucoma	☐		
		Anxiety	☐
Nasal Allergies	☐	Depression	☐
Sleep Apnea	☐	Diabetes	☐
		Thyroid Dysfunction	☐
Blood Clots/DVT	☐		
High/Elevated Cholesterol	☐	Anemia	☐
		Hemophilia	☐
Heart Attack	☐		
High Blood Pressure	☐	HIV	☐
Asthma	☐		
Chronic Bronchitis	☐		
Emphysema	☐		
Tuberculosis	☐		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Unspecified Cancer	☐	☐	☐	☐	☐
Hearing Loss before age 20	☐	☐	☐	☐	☐
Hearing Loss after age 20	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐	☐

4. Mark if retired. Yes ☐

5. Tobacco Use:
Mark your tobacco use.

☐ None ☐ Cigarettes
☐ Smokeless Tobacco ☐ Cigars

Give the closest amount of cigarettes you smoke in an average day.

☐ 1/2 pack ☐ 2 packs
☐ 1 pack ☐ 3 packs
☐ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

☐ Less than 12 drinks/yr
☐ 1-13 drinks/mo
☐ 4-14 drinks/wk
☐ >2 drinks/day

6. Do you use drugs recreationally? Yes ☐

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

☐ None ☐ 2-3 per day
☐ 1 per day ☐ 4 or more

8. Are you exposed to second hand smoke? Yes ☐

9. Mark if patient attends daycare. Yes ☐

10. Will you accept transfusion of blood products if necessary? Yes ☐

11. Home Living Situation (mark all that apply).

☐ Alone ☐ With spouse
☐ With children ☐ In nursing home
☐ With mother ☐ With father
☐ In assisted living ☐ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	☐
Sleeping problems	☐
Unintentional weight loss	☐
Unintentional weight gain	☐
Blurred vision	☐
Itchy eyes	☐
Loss of vision	☐
Painful eye	☐
Dizziness	☐
Ear drainage	☐
Hearing loss	☐
Ear pain	☐
Ringing in the ears	☐
Nasal congestion	☐
Frequent nosebleeds	☐
Post-nasal drainage	☐
Belching sour material into throat	☐
Hoarseness or other voice changes	☐
Mouth ulcers	☐
Partials or dentures	☐
Blacking out or fainting	☐
Chest pain	☐
Heart murmur	☐
Irregular heartbeats	☐
Leg cramps	☐
Swelling of ankles	☐
Frequent non-productive cough	☐
Frequent productive cough	☐
Shortness of breath	☐
Snoring (excessive)	☐
Wheezing	☐
Abdominal pain	☐
Diarrhea	☐
Heartburn	☐
Nausea	☐
Trouble swallowing	☐
Painful swallowing	☐
Vomiting	☐
Painful joints	☐
Stiffness in joints	☐
Swelling of joints	☐

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	☐
Change in sense of taste	☐
Headache	☐
Severe face pain	☐
Seizures	☐
Tremor	☐
Appetite is increased	☐
Fatigue	☐
Cold feeling	☐
Bleed excessively after injury	☐
Bruise easily	☐
Masses (lumps) in armpit	☐
Masses (lumps) in neck	☐
Masses (lumps) in groin	☐
Hives	☐
Sneezing	☐

Thank you for completing this questionnaire!

Coastal Carolina ENT

Otolaryngology-Head and neck surgery- Facial plastic and Cosmetic Surgery- Allergy

ERIC KENYON, DO JAMES DIMUZIO,DO MATTHEW BRENNAN, DO JEFFREY G. COURY, DO MICHAEL D. PETERS,MD
SAVANNAH WARD, NP TODD STUGART, NP

PATIENT INFORMATION

First Name: _____ Last name: _____

Social Security Number: _____ (*This is needed for insurance purposes only*)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____-_____ Cell Phone: ( ) _____- _____

Gender: Male: _____ Female: _____ Marital Status: _____

Date of Birth: _____ Email: _____

*** *Statements **will be sent by email**. If you prefer to be sent by USPS, please check here.*_____

FINANCIALLY RESPONSIBLE: (other than the patient)

First Name: _____ Last name: _____

Mailing Address: _____

Date of Birth: _____ Social Security Number: _____

Relationship to Patient:_____

PLEASE READ AND SIGN BELOW:

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits to be made directly to COASTAL CAROLINA ENT. Any balance left after insurance payment has been received will be due within 90 days of notification from this office. I further understand that any sums due to me, if less than $100.00, will be credited to my medical account. If sums due to me are more than $100.00, a check will be issued and mailed to address given. This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

I have read and understood all of the above and have given truthful information to the best of my knowledge.

Signature: _____ Date: _____

302 Liberty Street
Whiteville, NC 28472
(910) 914-0540(P)
(910) 914-0640(F)

2298 Ocean Hwy W
Supply, NC 28462
(910) 755-3682(P)
(910)755-6923(F)

3806 Sawtell Rd
Little River, SC 29566
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Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out your information to the best of your knowledge. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into our computer and you may have a copy at your request.

Full Name: _____ Date of birth:_____

Pharmacy Preference (name and location): _____

Primary Care Doctor: (name and location): _____

Current Height: _____ Current Weight: _____

CURRENT MEDICATIONS: (*this includes prescription, over the counter and/or herbal medications*)

Medication Name	Dosage	How often?

Are you allergic to any medications? Yes _____ No _____ If yes, please list below:

_____

Have you had any previous surgeries or procedures? Yes_____ No_____ If yes, please list below:

What is the reason for your visit today? _____

How long have you been experiencing this problem? _____

Did another physician refer you to us? (is so, please tell us who?) _____

Signature: _____ Date: _____

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Designation of Caregivers for Communication of Protected Health Information

Patient Name: _____ Current Date: _____

Date of Birth: _____

At my request, ***I authorize the person(s) below to inquire about my personal health and/or billing information*** on my behalf. In case of a minor, this person(s) may inquire about their child's personal health and/or billing information. If necessary, this person may bring the child to appointments on my behalf.

Name	Relationship	DOB	Phone Number

OR

_____ (initial) I DO NOT want my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize COASTAL CAROLINA ENT to communicate my protected health information to me via the following methods: (Check all that apply)

____ Leave a DETAILED MESSAGE on my *HOME* voicemail: Phone Number: _____
____ Leave a DETAILED MESSAGE on my *CELL* voicemail: Phone Number: _____
____ Leave a MESSAGE with *CALL BACK* number only. Phone Number: _____
____ Leave a DETAILED MESSAGE on my *WORK voicemail* Phone Number: _____
____ FAX DETAILED medical information to *ME*: Fax Number: _____

Authorized Patient or Guarantor Signature: _____ Date: _____

Print Name: _____

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PATIENT SCREENING

First Name: _____ Last Name: _____

Date Of Birth: _____ Weight: _____Height: _____' _____"

Please indicate if you have had the following screenings and/or vaccinations.

If so, when were they done?

	Yes	No	When/Last?
Influenza Vaccine (Flu Vaccine)	____	____	_____
Tdap Vaccination (Tetanus)	____	____	_____
Herpes Zoster Vaccination (Shingles)	____	____	_____
Pneumococcal Vaccine (Pneumonia Vaccine)	____	____	_____
Current Smoker	____	____	_____
Advance Care Plan (List Person)	_____		

Signature: _____ Date: _____

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DIAGNOSTIC SCOPE/PROCEDURE

If you are here for a **SINUS OR THROAT** issue, the doctor may need to perform a diagnostic scope/procedure. A nasal endoscopy is a procedure to look at the nasal and sinus passages. It's done with an endoscope. This is a thin, flexible, or rigid tube with a tiny camera and a light. If this procedure is needed, your doctor will speak to you beforehand.

We want to inform you that there will be an additional charge sent to your insurance company this. Some insurance companies will bill this as a "surgery" and this charge may go towards your deductible.

If you are a self-pay patient, this will be an additional charge needing to be paid at time of check-out.

I agree to have this scope/procedure done and I will be responsible for any bills that may occur in reaction to this.

Signature: _____

Print Name: _____ Date: _____

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COASTAL CAROLINA ENT, DO, PA

PATIENT PRIVACY HIPAA NOTICE FORM

ERIC KENYON, DO JAMES DIMUZIO,DO MATTHEW BRENNAN, DO JEFFREY G. COURY, DO MICHAEL D. PETERS,MD
SAVANNAH WARD, NP TODD STUGART, NP

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was created to provide a standard for health providers to obtain their patient's consent for use and disclosure of heath information about the patient, to carryout out treatment, payment, or health care operations.

As our patient, we assure you that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we only provide the minimum information required to those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

In addition, please note that we request full access to your personal medical records. We may have direct treatment relationships (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations.

You may refuse to authorize the use or disclosure of your personal health information, but this MUST be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your PHI (Personal Health Information). Please be aware that signing, you may not ask to revoke and refuse PHI.

If you have any objections to this form, you have a right to speak to our HIPAA Compliance officer.

Signature: _____

Printed Name: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

COASTAL CAROLINA ENT, DO, PA

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to be certain that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability (HIPAA) with particular emphasis on the "PRIVACY RULE". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We know that we are not perfect, and because of this, our policy is to listen to our employees and our patients without any thought of penalization if they feel that in any way a compromise has been made against our PHI.

Thank you for choosing Coastal Carolina ENT.

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