David C. Brodner, M.D.

Sinus, Allergy, Sleep

Board-Certified in Otolaryngology—Head and Neck Surgery
Board-Certified in Sleep Medicine

Patient Name:_____ **Email Address:**_____

SSN:_____ **Date of Birth:**_____ **Age:**_____ **Sex:** F_____ M_____

Race: American Native/Alaska Native ___ Asian ___ Black/African American ___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino___ Declined to answer ___

Patient Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Patient's Phone # (___) _____ **Cell** (_____) _____ **Marital Status** M_S__D__W__

Emergency Contact:_____ **Relationship** _____ **Phone #:**_____

Primary Care Physician:_____ **Referred By:**_____

Primary Insurance Company_____ **Subscriber Name:**_____ **Date of Birth:**_____

Relationship to Patient:_____ **Secondary Insurance Company:**_____

List below any person/family member whom you authorize access to your medical records and/or authorize us to leave a detailed message regarding all aspects of your medical chart, health condition, medications, and financial history.

Name:_____ **Relationship:**_____

We are converting to an electronic prescribing system and we will need the following information:

Pharmacy Name:_____ **Address or Cross Streets:**_____

Phone #:_____

Patient/Legal Guardian Signature:_____ **Date:**_____

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Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to Ear, Nose & Throat Associates of South Florida on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT Associates of South Florida, PA., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), **endoscopes**, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. **I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to my plan's deductible and/or co-insurance. Total charges for services rendered will be due at time of service.**

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

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PBM Consent

By signing this consent form I am authorizing Ear, Nose and Throat Associates of South Florida to request and use my prescription medication history from other health care providers and/or third party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

Ear, Nose and Throat Associates of South Florida uses a third party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/Legal Guardian Signature:_____ **Date:**_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/Legal Guardian Signature:_____ **Date:**_____

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ M or F

Referring or Primary Care Physician: _____ Pharmacy: _____

Briefly, why are you seeing our physician today? _____

Weight: _____ **Height:** _____ **Allergies to Medication:** _____

Social History – Have you ever smoked? (Yes) ____ (No) ____

You now smoke_____packs of cigarettes a day.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

You consume_____glasses of water per day.

1. **Surgeries** - Please list any surgeries/hospitalizations: _____

_____

2. **Patient History** - Please check your response

	Yes	No
Cancer _____	( )	( )
Heart_____	( )	( )
Cardio: Hypertension	( )	( )
Ear: Dizziness	( )	( )
Ear: Hearing Loss	( )	( )
Ear: Tinnitus/Ringing in ear	( )	( )
Endocrine: Diabetes	( )	( )
Endocrine: Thyroid Disorders	( )	( )
G.I: Bowel Disorder _____	( )	( )
G.I: Livers Disorder	( )	( )
G.I: Stomach Disorders _____	( )	( )
G.I: Reflux/GERD/Heartburn	( )	( )
Immuno: HIV	( )	( )
Immuno: Immune Diseases	( )	( )
Lymph: Anemia	( )	( )

	Yes	No
Lymph: Bleeding Disorders	( )	( )
Nasal: Allergies	( )	( )
Nasal: Nasal Trauma	( )	( )
Nasal: Sinusitis	( )	( )
Nasal: Nose Bleeds	( )	( )
Neuro: Nervous System	( )	( )
Neuro: Seizure Disorder	( )	( )
Ophth: Eyes/Glaucoma	( )	( )
Oral: Sleep Apnea	( )	( )
Pysch: Psychiatric Disorders	( )	( )
Pulm: Lungs	( )	( )
Pulm: Tuberculosis	( )	( )
Uro: Bladder Disorders	( )	( )
Uro: Kidney	( )	( )

Details on Yes Answers:

_____

3. **Family History** - Please check your response

	Yes	No
Allergies	( )	( )
Cancer	( )	( )
Diabetes	( )	( )

	Yes	No
Sinusitis	( )	( )
Sleep Apnea	( )	( )
Thyroid Disorders	( )	( )
Immune Disease	( )	( )
Headaches/Migraine	( )	( )
Premature Hearing Loss	( )	( )

Patient Signature: _____ Date: _____

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In order to best serve your needs,

Please answer all eight questions, even if your problem today does not involve sleep or sinus issues.

1) Complete the following:
   Height _____ Age _____
   Weight _____ Male/Female _____

2) Do you snore loudly (bothersome to other people)?
   Yes _____ No _____ Not sure _____

3) Has anyone noticed that you quit breathing during your sleep?
   Yes _____ No _____

4) Do you feel tired or sleepy during the day?
   Yes _____ No _____

5) Do you take medicine to control high blood pressure?
   Yes _____ No _____

6) Do you suffer from a stuffy/congested nose?
   Yes _____ No _____

7) Do you suffer from sinus headaches or pressure?
   Yes _____ No _____

8) How many times have you needed sinus treatment (by yourself or from a doctor) in the past 12 months?

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ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ No Known Drug Allergies

MEDICATIONS: Date: _____ Reconciled by: _____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: ☐ Yes ☐ No**

Patient/Legal Guardian Signature:_____ Date:_____

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Informed Consent

Endoscopy of the Nose and Upper Airway

Please be aware that certain endoscopic procedures performed in our office are not included in the standard office visit. These procedures will be billed separately in addition to the office visit charges and may be subjected to your deductible and co insurance as some insurance companies may list this diagnostic procedure as "surgery" on the explanation of benefits form that you receive.

Patients presenting to our office with sinus, allergy, throat or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This diagnostic examination is essentially painless and, in many cases can be accomplished quickly. These procedures have almost no risk and provide your physician with an excellent view of the areas involved. Complications may include: Bleeding, reaction to the topical anesthesia, pain and coughing or shortness of breath. These are all very rare.

Please sign below to acknowledge that you have read the above and agree to undergo the procedure as deemed necessary by your physician upon your visit.

- Nasal Endoscopy 31231
- Flexible Laryngoscopy 31575
- Nasopharyngoscopy 92511
- Nasal/Sinus debridement 31237

AUTHORIZATION TO PERFORM PROCEDURE:

Patient Name **Date** **Physician**

_____ _____ _____

_____ _____ _____

Signature Witness Patient/Guardian

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