

# PATIENT HEALTH HISTORY FORM



Robert J. Sciacca, M.D.  
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4515 Southlake Parkway – Suite 300 • Hoover, AL 35244 • Phone: 205.985.7393 • FAX: 205.987.1332

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for today's visit (be as brief as possible):  Ears: \_\_\_\_\_  Nose: \_\_\_\_\_

Throat: \_\_\_\_\_  Other: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Physician Phone Number: (\_\_\_\_) \_\_\_\_\_

Is current problem is the result of? (check all that apply)  Work accident  Motor vehicle accident  Accident  Other

## I. PAST MEDICAL HISTORY

1. Please list prior illnesses and/or injuries (give dates if known):

Description Of Illness or Injury	Approximate Date(s)

2. Please list any known allergies, including foods:


3. Please list all surgeries and/or hospitalizations (give dates, if known):

Description Of Surgery Or Hospitalization	Approximate Date(s)

4. Have you ever had problems with anesthesia? (if yes, please explain):  No  Yes \_\_\_\_\_

5. Please list all current medications. Provide drug name, dosage and frequency.

M E D I C A T I O N	D O S A G E	F R E Q U E N C Y

6. Are you allergic to any medications? (if yes, please list):  No  Yes \_\_\_\_\_

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## II. FAMILY HISTORY

1. Please fill-in completely, placing a "II" in the boxes that apply:

Family Member	Living	Age	Deceased	Age at death	Health Status/Cause of Death
Mother .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Father .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Grandmother (mom's) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Grandfather (mom's) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Grandmother (dad's) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Grandfather (dad's) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Brother/Sister (circle one) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Brother/Sister (circle one) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Brother/Sister (circle one) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Brother/Sister (circle one) .....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____

## III. SOCIAL HISTORY

- Are you currently:  Working full time  Working part-time  Disabled  Retired (when) \_\_\_\_\_
- Current/previous occupation: \_\_\_\_\_ For how long? \_\_\_\_\_
- Marital Status:  Single  Married  Separated  Divorced  Widowed
- Do you have children?  No  Yes (How many?) \_\_\_\_\_
- Do you live alone?  No  Yes (If "no," who lives with you?) \_\_\_\_\_
- Use of Tobacco:  No, I've never smoked or used smokeless tobacco products (E.g. snuff, chew, etc.)  
 No, I previously used, but have quit using smokeless tobacco products  
 No, I quit smoking \_\_\_ years ago (At that time I smoked \_\_\_ packs per day for \_\_\_ years)  
 Yes, I smoke cigars/pipe.  
 Yes, I use smokeless tobacco products  
 Yes, I smoke cigarettes occasionally, but not daily.  
 Yes, I've smoked \_\_\_ packs of cigarettes per day for \_\_\_ years.
- Alcohol consumption:  None; never (or rarely)  
 No, but I have previously  
 Yes, 1 or more times per month  
 Yes, 1 or more times per week  
 Yes, daily.
- Illegal drug use:  No  
 No, but I have previously  
Type/frequency \_\_\_\_\_  
 Yes, presently  
Type/frequency \_\_\_\_\_
- Are you at risk for AIDS? (E.g. sexually active; sexual orientation, drug abuse, previous blood transfusion)  
 No  Yes (please explain): \_\_\_\_\_
- Caffeine intake: \_\_\_\_\_ per day Source: \_\_\_\_\_
- Do you exercise?  No  Yes (type/frequency): \_\_\_\_\_

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#### IV. REVIEW OF SYSTEMS

Are you currently having, or have you ever had problems with (*please complete each item*):

##### CONSTITUTIONAL

- Fever .....  Never  Currently  In the past  
Weight loss .....  Never  Currently  In the past  
Excessive fatigue..  Never  Currently  In the past  
Night sweats .....  Never  Currently  In the past

##### EYES

- Wear glasses .....  Never  Currently  In the past  
Wear contacts .....  Never  Currently  In the past  
Date of last eye exam: \_\_\_\_\_  
Eye infections .....  Never  Currently  In the past  
Eye injury .....  Never  Currently  In the past  
Glaucoma.....  Never  Currently  In the past  
Cataracts.....  Never  Currently  In the past

##### EARS, NOSE, MOUTH & THROAT

- Hearing aid .....  Never  Currently  In the past  
Date of last hearing exam: \_\_\_\_\_  
Hearing loss .....  Never  Currently  In the past  
Ear pain .....  Never  Currently  In the past  
Ear infections.....  Never  Currently  In the past  
Ringing in ears ....  Never  Currently  In the past  
(*if ringing, check*)  Both  Left  Right  
Balance problems  Never  Currently  In the past  
Nosebleeds.....  Never  Currently  In the past  
Nasal congestion..  Never  Currently  In the past  
Nasal drainage ....  Never  Currently  In the past  
Sinus infections ....  Never  Currently  In the past  
Sinus headaches..  Never  Currently  In the past  
Sore throat.....  Never  Currently  In the past  
Mouth sores.....  Never  Currently  In the past

##### CARDIOVASCULAR

- Chest pain .....  Never  Currently  In the past  
EKG .....  Never  Date of last: \_\_\_\_\_  
High blood press ..  Never  Currently  In the past  
Irregular pulse ....  Never  Currently  In the past  
Heart murmur .....  Never  Currently  In the past  
High cholesterol....  Never  Currently  In the past

##### RESPIRATORY

- Asthma.....  Never  Currently  In the past  
Chronic cough .....  Never  Currently  In the past  
Emphysema .....  Never  Currently  In the past  
Shortness(breath)  Never  Currently  In the past  
Bronchitis.....  Never  Currently  In the past  
Pneumonia .....  Never  Currently  In the past  
Lung cancer.....  Never  Currently  In the past  
Bloody sputum.....  Never  Currently  In the past  
Chest X-ray.....  Never  Date of last: \_\_\_\_\_

##### GASTROINTESTINAL

- Indigestion.....  Never  Currently  In the past  
Nausea .....  Never  Currently  In the past  
Vomiting .....  Never  Currently  In the past  
Blood in vomit.....  Never  Currently  In the past  
Liver disease .....  Never  Currently  In the past  
Jaundice .....  Never  Currently  In the past  
Abdominal pain ....  Never  Currently  In the past  
Change in bowel ...  Never  Currently  In the past  
habits  
Ulcers/Gastritis.....  Never  Currently  In the past  
Colon cancer.....  Never  Currently  In the past

##### GENITOURINARY

- Urinary tract infect  Never  Currently  In the past  
Painful urination....  Never  Currently  In the past  
Blood in urine.....  Never  Currently  In the past  
Difficulty urinating .  Never  Currently  In the past  
Incontinence .....  Never  Currently  In the past  
Kidney stones .....  Never  Currently  In the past  
Prostate cancer ....  Never  Currently  In the past  
Endometriosis.....  Never  Currently  In the past  
Uterine cancer .....  Never  Currently  In the past  
Cervical cancer .....  Never  Currently  In the past

##### MUSCULOSKELETAL

- Broken bones.....  Never  Currently  In the past  
(*List with dates*): \_\_\_\_\_

- Arm/leg weakness  Never  Currently  In the past  
Back pain .....  Never  Currently  In the past  
Joint pain.....  Never  Currently  In the past  
Joint swelling .....  Never  Currently  In the past  
Arthritis.....  Never  Currently  In the past

##### INTEGUMENTARY

- Skin disease .....  Never  Currently  In the past  
Skin cancer .....  Never  Currently  In the past  
Breast pain.....  Never  Currently  In the past  
Breast swelling ....  Never  Currently  In the past  
Nipple discharge...  Never  Currently  In the past  
Mammogram.....  Never  Date of last: \_\_\_\_\_  
Results: \_\_\_\_\_

##### ALLERGIC/IMMUNOLOGIC

- Food allergies .....  Never  Currently  In the past  
Nasal allergies .....  Never  Currently  In the past  
Immunologic .....  Never  Currently  In the past  
disorders

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**IV. REVIEW OF SYSTEMS (continued)**

Are you currently having, or have you ever had problems with (*please complete each item*):

**NEUROLOGICAL**

- Fainting or ..... Never  Currently  In the past  
"blacking out"
- Seizures..... Never  Currently  In the past
- Memory problems . Never  Currently  In the past
- Disorientation ..... Never  Currently  In the past
- Speech difficulties . Never  Currently  In the past
- Inability to ..... Never  Currently  In the past  
concentrate
- Double or..... Never  Currently  In the past  
blurred vision
- Weakness of face.. Never  Currently  In the past
- Coordination..... Never  Currently  In the past  
problems

**PSYCHIATRIC**

- Anxiety..... Never  Currently  In the past
- Depression ..... Never  Currently  In the past
- Schizophrenia..... Never  Currently  In the past
- Manic depressive.. Never  Currently  In the past
- Other: \_\_\_\_\_

**ENDOCRINE**

- Diabetes..... Never  Currently  In the past
- Thyroid disease .... Never  Currently  In the past
- Increased appetite  Never  Currently  In the past
- Excessive ..... Never  Currently  In the past  
urination
- Excessive thirst..... Never  Currently  In the past
- Hormone ..... Never  Currently  In the past  
problems

**HEMATOLOGIC/LYMPHATIC**

- Anemia ..... Never  Currently  In the past
- Hemophilia ..... Never  Date: \_\_\_\_\_
- Bleeding ..... Never  Currently  In the past  
tendencies
- Persistent ..... Never  Currently  In the past  
swollen glands
- Blood transfusion.. Never  Date: \_\_\_\_\_

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

\_\_\_\_\_  
Patient Signature Date

I have reviewed the above information with the patient:

\_\_\_\_\_  
Physician Signature Date

**FOR OFFICE USE ONLY**

*(do not write in this space)*

# PATIENT REGISTRATION FORM



Robert J. Sciacca, M.D.  
J. Christopher Davis, M.D.

4515 Southlake Parkway – Suite 300 • Hoover, AL 35244 • Phone: 205.985.7393 • FAX: 205.987.1332

Referred By (Primary Care Physician, if required by Ins. Co.): \_\_\_\_\_  
Physician Address: \_\_\_\_\_ Physician Phone Number: (\_\_\_\_) \_\_\_\_\_

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Suffix (Jr., etc.): \_\_\_\_\_ Nickname: \_\_\_\_\_  
Street Address: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  
Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Marital Status:  S  M  D Name of Employer: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company	Secondary Insurance Company
Company Name: _____	Company Name: _____
Group #: _____ Pol#: _____ Eff Date: _____	Group #: _____ Pol#: _____ Eff Date: _____
Relationship to Patient: _____	Relationship to Patient: _____
Name of Insured (on card): _____	Name of Insured (on card): _____
Address of Insured: _____	Address of Insured: _____
Zip Code: _____ City: _____ State: _____	Zip Code: _____ City: _____ State: _____
Insured's Social Security Number: _____	Insured's Social Security Number: _____
Home Phone: (____) _____ Work Phone: (____) _____	Home Phone: (____) _____ Work Phone: (____) _____
Insured's Date of Birth: _____	Insured's Date of Birth: _____
Insured's Employer: _____ Copay: \$ _____	Insured's Employer: _____ Copay: \$ _____

## EMERGENCY NOTIFICATION INFORMATION

Contact Person (other than spouse): \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## INJURY INFORMATION

Job Related?  yes  no Date of Injury: \_\_\_\_\_ Date Last Worked: \_\_\_\_\_ Employer (then): \_\_\_\_\_  
Workman's' Comp Carrier: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_\_  
How did injury occur? \_\_\_\_\_  
Employer rep who authorized treatment: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Relationship to Patient: \_\_\_\_\_ Responsible Party: \_\_\_\_\_ SSN: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
Employer Street Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

## CONSENT FOR TREATMENT – RELEASE OF MEDICAL INFORMATION – FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize the release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any service rendered by Alabama ENT Associates and understand that payment of charges incurred in the office is due at the time of services. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Alabama ENT Associates. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney fees and hereby waives all right of exemption under the Constitution of the State of Alabama.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

**Robert J. Sciacca, M.D.**

**J. Christopher Davis, M.D.**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

#### **Uses and Disclosures**

**TREATMENT:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**PAYMENT:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**HEALTH CARE OPERATIONS:** Your health information may be used as necessary to support the day-to-day activities and management of Alabama ENT. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**LAW ENFORCEMENT:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**PUBLIC HEALTH REPORTING:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

#### **Additional Uses of Information**

**APPOINTMENT REMINDERS:** Your health information will be used by our staff to send you appointment reminders.

**INFORMATION ABOUT TREATMENTS:** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**INDIVIDUAL RIGHTS:** You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

*(Please Turn Over – Continued on backside)*

### **ALABAMA ENT DUTIES**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

### **RIGHT TO REVISE PRIVACY PRACTICES**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Medical Records Clerk or our Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **COMPLAINTS**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Debaroh Junkins, Privacy Officer  
Alabama ENT  
4515 Southlake Parkway  
Suite 300  
Birmingham, AL 35244

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

### **CONTACT PERSON**

The name and address of the person you may contact for further information concerning our privacy practices is:

Debaroh Junkins, Privacy Officer  
Alabama ENT  
4515 Southlake Parkway  
Suite 300  
Birmingham, AL 35244  
205-985-7393

### **EFFECTIVE DATE**

This notice is effective on or after April 16, 2003.

# Acknowledgements And Permissions Form



Robert J. Sciacca, M.D.  
J. Christopher Davis, M.D.

4515 Southlake Parkway \_ Suite 300 \_ Hoover, AL 35244 \_ Phone: 205.985.7393 \_ Fax: 205.987.1332

## SECTION I—Acknowledgement of Receipt of *Notice of Privacy Practices*

Alabama ENT reserves the right to modify the privacy practices outlined in *The Notice of Privacy Practices*.

I have received a copy of the ***Notice of Privacy Practices for Alabama ENT***.

\_\_\_\_\_  
Name of Patient *(please print or type using blue or black ink)*

\_\_\_\_\_  
Signature of Patient or Patient Representative *(if patient is a minor or unable to sign this form).* Date

Relationship of Patient Representative to Patient: \_\_\_\_\_

## SECTION II—Permission to Leave Information

It may be necessary to contact you by phone concerning test results and/or other pertinent medical information. In the event that we cannot reach you by phone, your permission is required to leave this information with a third party or recording device. Please read and complete the following:

\_\_\_\_\_ *(Please initial)* I give Alabama ENT Associates permission to leave their office name and phone number at my home phone number.

\_\_\_\_\_ *(Please initial)* I give Alabama ENT Associates permission to leave their office name and phone number at my work phone number.

\_\_\_\_\_ *(Please initial)* I give Alabama ENT Associates permission to give test results and/or pertinent medical information to: *(please check all for which permission is given)*

Spouse                       Answering machine/voicemail (home)

Parent                         Answering machine/voicemail (work)

Other: \_\_\_\_\_

## SECTION III—Acknowledgement and Acceptance of Cancellation Policies

The policies of Alabama ENT Associates for appointment and surgery cancellations are as follows:

— Office visits must be cancelled within 24 hours of scheduled appointment time. ***Patient will be liable for a \$35.00 scheduling fee*** for cancellations less than 24 hours in advance.

— Scheduled surgeries must be cancelled 72 hours prior to scheduled surgery time. ***Patient will be liable for a \$200.00 scheduling fee*** for cancellations less than 72 hours in advance.

By signing below, I certify that I have read and accept Alabama ENT Associates' Cancellation Policy. I realize that my insurance *will not* compensate me for these fees.

\_\_\_\_\_  
Signature of Patient or Patient Representative *(if patient is a minor or unable to sign this form)* Date