ROCKY MOUNTAIN EAR, NOSE AND THROAT
PATIENT INFORMATION

Date:_____
Patient's Legal Name:

(last)_____(first)_____(mid initial)_____

Preferred/Nickname:_____

Mailing Address:_____

City:_____ Zip:_____

Phone numbers: Home: _____ Mobile: _____

Email: _____

Date of Birth (mm/dd/yyyy): ___/___/___Age:_____ Sex: M/F SSN:_____

Marital Status:❑Married ❑Single ❑Divorced ❑Other:_____

Patient Employer: _____ Work Phone:_____

Emergency Contact: _____Phone: _____

## GUARANTOR INFORMATION

Person responsible for payment: _____

Relationship to patient: _____

## INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Member Number: _____

Group Number:_____

Secondary insurance (If any): _____

Primary Rx Insurance: _____

Group #:_____ Rx BIN #:_____ Rx PCN #: _____

Specialty Pharmacy Name:_____

Phone #:_____ Fax #: _____

Primary Care Physician (PCP): _____ Referring Physician: _____

Have you previously been seen at our practice? Y/ N Date Last Seen: _____

## VOICE MESSAGE CONSENT

If I am unable to be reached directly by phone, I authorize you to leave voice messages for me at the following.
number(s): Home: _____ Work: _____ Cell: _____ Other: _____
I give permission for Name: _____ To receive my information.

## AUTHORIZATIONS AND PRIVACY PRACTICES

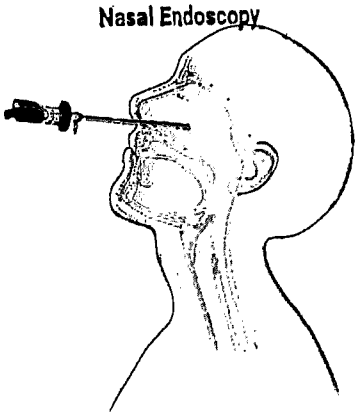
Payment and Release of Information: By signing below, thereby authorize payment to be made directly to my physician, for medical and/or surgical benefits, if any. A copy of this authorization shall be valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance. I hereby authorize ROCKY MOUNTAIN ENT GROUP to release information requested by my insurance company, I also authorize ROCKY MOUNTAIN ENT GROUP to release information to any hospital or physician I may be referred to by this office,

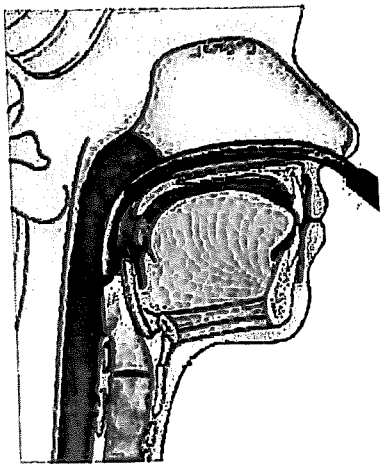
Notice of Privacy Practices: By signing below, I hereby acknowledge that I received a copy of the Notice of Privacy Practices

SIGNATURE: _____ DATE: _____

## Endoscopy/Laryngoscopy

Nasal Endoscopy





Flexible Laryngoscopy

These are common and important diagnostic procedures that ENT providers utilize to help visualize difficult anatomy. These common endoscopy procedures are important diagnostic tools.

### Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider inserts a rigid or flexible endoscope in the nasal cavity. The provider will extend the scope along the floor of the nasal cavity into the nasopharynx. The provider examines the entire nasopharynx and then passes the scope between the middle and the inferior turbinates. The provider then repositions the head of the endoscope to an angle and advances it into the olfactory cleft to look for any polyps. If provider is evaluating the entire upper airway, they will continue to advance the scope to the level of the vocal cord before removing. The procedure is easy to execute and does not require any incision. The provider may perform the endoscopy on one of both sides.

**According to The Centers for Medicare & Medicaid Services (CMS) a surgical procedure is defined as:**

Surgical and other invasive procedures and defined as operative procedures in which skin or mucous membranes and connective tissue are incised **or an instrument is introduced through a natural body orifice.** Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. **They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT)** and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar.

If your condition requires an endoscopy/laryngoscopy **you may be responsible for any charges that exceed the maximum allowable amount your insurance will pay for this exam.**

I have read and fully understand

Responsible Party (Please Print Name) _____

Sign and Date _____

**Endoscopy/Laryngoscopy:** If your condition requires an endoscopy/laryngoscopy, a fiber optic scope may be utilized in the office to further evaluate and treat your condition. Please be aware that the American Medical Association notes that this is a surgical procedure. **You may be responsible for any charges that exceed the maximum allowable amount your insurance will pay for this exam.**

**Credit Card Fee:** Starting January 1st, 2024, Rocky Mountain ENT will be implementing a 2% credit card fee to all transactions made using a credit card.

I have read and fully understand and agree with all terms set forth in the above Office Policy.

Responsible Party (Please Print Name) _____

Sign and Date _____

Today's Date: _____ **ROCKY MOUNTAIN ENT** Health History Form

**PLEASE: Answer ALL questions, fill in ALL blanks, & fill out ALL paperwork (front AND back).**
**If something does not apply to you, please write N/A.**

Name: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____

Referring Physician (if different than PCP): _____

Preferred Pharmacy: _____ Height: _____ Weight: _____

**MEDICAL HISTORY**: Please check all that apply

- ❑ Abnormal bleeding
- ❑ Artificial Heart Valve
- ❑ Acid Reflux/GERD
- ❑ Anemia/Sickle Cell
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune Disorder
  If yes, please list:
  _____
- ❑ Cancer
- ❑ Cardiovascular Disease
- ❑ Chemo/Radiation
- ❑ Cold Sores
- ❑ Congenital Heart Failure
- ❑ Coronary Heart Disease
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ Diabetes
  If yes, Type I or Type II?
  _____
- ❑ Epilepsy/Seizures
- ❑ Glaucoma
- ❑ Hearing loss
- ❑ Heart Attack
- ❑ Heart Arrhythmia
- ❑ Heart Murmur
- ❑ High Cholesterol
- ❑ High/Low Blood Pressure
- ❑ HIV/AIDs
- ❑ Kidney Disease
- ❑ Liver Disease/Hepatitis
- ❑ Migraines
- ❑ Neurological Disorder
  If yes, please list:
  _____
- ❑ Mental Health Disorder
  If yes, please list:
  _____
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pulmonary Disease
- ❑ Rheumatic Fever
- ❑ Seasonal Allergies
- ❑ Sleep Apnea
- ❑ Thyroid Disease
  If yes, please list:
  _____
- ❑ Tinnitus
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vertigo
- ❑ Organ Transplant

Other medical history (if not listed above): _____

_____

**SURGICAL HISTORY** (please provide date(s) if known): ☐ Check if NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____

**ALLERGIES** to medications: ☐ Check if NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE SEE REVERSE →

**CURRENT MEDICATIONS** (Please provide dosages if known):
**Include** prescriptions, over-the-counter medications, vitamins/supplements, etc.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you take Aspirin? **YES** or **NO**

Do you take any other blood thinners? (Coumadin/Warfarin, Plavix, Eliquis, Xarelto, Brilinta, etc.)
If **yes**, please list (with dose): _____
_____

**FAMILY HISTORY** (please list medical illnesses + relationship):

_____ _____ _____
_____ _____ _____
_____ _____ _____

**SOCIAL HISTORY**:

Cigarette use (please circle): Never Smoker Former Smoker Current Smoker

- If **current** or **former** smoker: _____# pack per day, _____# of years
- If **former** smoker, please list year quit: _____

Chewing tobacco use: **YES** or **NO**. If **yes**- how much and how often? _____

Nicotine Vape use: **YES** or **NO**. If **yes**- how often? _____

Marijuana use: **YES** or **NO**. If **yes**- how much and how often? _____

Alcohol use: **YES** or **NO**. If **yes**- how many drinks per week? _____

Other drug use: **YES** or **NO**. If **yes**- what substance and how often? _____

Caffeine use: **YES** or **NO**. If **yes**- how much per day? _____

Please check any recent symptoms you've been experiencing that you would like to discuss during your appointment:

| | |
|---|---|
| ❑ EASY BRUISING | ❑ CANCER TREATMENTS |
| ❑ HEARING LOSS | ❑ TROUBLE SWALLOWING |
| ❑ RINGING/TINNITUS | ❑ CHRONIC COUGH |
| ❑ VERTIGO | ❑ CHRONIC HOARSENESS |
| ❑ RECENT CHANGE IN VISION | ❑ SNORING |
| ❑ NASAL OBSTRUCTION | ❑ PULMONARY PROBLEMS |
| ❑ NASAL BLEEDING | ❑ ARTHRITIS |
| ❑ NASAL FRACTURE (recent or in the past) | OTHER: |
| ❑ RECENT DENTAL WORK | |
| ❑ RADIATION EXPOSURE | |

ROCKY MOUNTAIN
Ear, Nose & Throat

Sinus Medications List

Name:_____

Date:_____

Please list or check any of the nasal or sinus medications you have recently taken:

Nasal Steroid Sprays

- ☐ Flonase (Fluticasone)
- ☐ Nasacort (Triamcinolone)
- ☐ Nasonex (mometasone)
- ☐ Other:_____

*How long have you used these sprays?*_____

Antihistamine Sprays

- ☐ Azelastine/Astepro

Saline Nasal Sprays: Yes/ No

Saline Irrigations

- ☐ Nielmed rinse
- ☐ Neti pot
- ☐ Navage

Antibiotics you have taken in the last 12 months

- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Bactrim
- ☐ Tetracycline
- ☐ Clindamycin
- ☐ Zithromax
- ☐ Augmentin (Amox/Clavulanate)
- ☐ Cephalexin
- ☐ Levaquin (Levofloxacin)
- ☐ Ciprofloxacin
- ☐ Avelox (Moxifloxacin)
- ☐ Other:_____

Decongestants/Antihistamines

- ☐ Allegra
- ☐ Claritin
- ☐ Zyrtec
- ☐ Mucinex/Mucinex D
- ☐ Sudafed
- ☐ Afrin/Neo Synephrine sprays