Patient's Last Name ________________________________ First Name ________________________________ Middle Initial ____

SSN ______________________ Date of Birth ______________ Age _________ Sex: F M

Address ______________________________________ City _______________ State ______ Zip _________ County____________

Name & Address of Primary Care (Family) Physician / Pediatrician ____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated☐ Student Status: PT FT

Home Phone ___________________________ Day Phone _________________________ Cell Phone _______________________

Employer: __________________________________ Employer Address: ____

What is or was your occupation? ____ ☐ Retired?

Name of Spouse/Parent/Legal Guardian ________________________________ DOB ___________ SSN ___________________

Primary Medical Insurance- Information needed in order to File Insurance

Policy Holder Name ______________________________ Policy Holder SSN __________________ Policy Holder DOB __________

Plan Name ________________ Policy Holder # __________________________ Patient's Policy # __________________________

Group Name (if applicable) _______________________ Group Number (if applicable) _______________

Secondary Medical Insurance

Policy Holder Name ____________________________ Policy Holder SSN __________________ Policy Holder DOB __________

Plan Name ________________ Policy Holder # _________________________ Patient's Policy # __________________________

Group Name (if applicable) _______________________ Group Number (if applicable) _______________

Workers' Comp
Is this visit covered by Workers' Comp? _________________________________ No Fault? ________________________________

***** Emergency Contact: ____________________________________ Phone #: _________________________________

Referring Physician____ Yellow pages______ Other____________________________

To allow for more efficient scheduling we require a 24 hour cancellation notice. In the event this is not met, a $25.00 fee will be charged to your account. Thank you for your cooperation.

____
Initials

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I hereby authorize Dr. Berger to obtain records from other sources as may be required in the treatment of this patient or to release information concerning this patient's treatment to other professionals. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received a copy of Dr. Berger's privacy practice.**

Patient Signature: ____ ***Date:*** _____________________

Parent or Responsible Party

JOSEPH BERGER,M.D. and SOUTH GA AUDIOLOGY & HEARING CENTER

Patient's Name ______________________________________ **Age** ________ **DOB** ____/______/___________

Chief complaint: ____

Duration (how long) ago did problem start: ____

Severity (mild, moderate, and severe):__________________ **Timing (constant, off & on, etc.)** ____________

Aggravating factors (things that make the problem worse):_______________________________________

Alleviating factors (things that help relieve

Associated symptoms (other symptoms that seem related to chief complaint):________________________
____

Have you been treated by a Physician for this problem? _____**no** ____**yes** **If so, what treatment was given?**
____

Medical History (***this information pertains to the patient only***)
Medication Allergies? ___ **no** ___ **yes** - please list ____
____
____

Food or Latex Allergy? ______ **no** ______ **yes** - please list ____

List previous EAR, NOSE OR THROAT operations, give date of procedure or age when performed
____ When?_______________________________
____ When?_______________________________
____ When? _______________________________

Have you ever had any problems associated with receiving general anesthesia?___**no** __**yes**
If yes, provide details____

Females only: If currently pregnant # weeks ___________________________ Breast feeding? ___no ___yes

Social History: *** (***this information pertains to the patient only***)
Tobacco use: ☐**Never** ☐ **Dip/chew** ☐ **cigarettes** ☐ **pipe** ☐ **cigars**
how much? ____________________ **how often?**____________________ **how long?**_________________
If you have stopped, when did you stop?_______________________________

Alcohol use: ☐**No** ☐**Yes** – List type _____________, amount_________________ & frequency___________
Drug use: ☐**No** ☐**Yes** – List type _____________, amount _________________& frequency___________

Infant / Toddler – currently in daycare setting? _____**no** _____**yes**

Misc: Have **you ever tested positive for Hepatitis or HIV?** ____**no** ____**yes**
If yes, explain____
Would you accept blood transfusion in the event of a life threatening situation? ___**no** ___ **yes**

Family History (***this information pertains to*** (***family members)-mother-father-sister-brother***)

☐**Hearing loss** ☐**Heart problems** ☐**Cancer** ☐**Diabetes** ☐**Thyroid Disease** ☐**Bleeding disorder** ☐**Sleep Apnea**
☐**Sinus / Allergy Problems** ☐**Anesthesia problems** ☐**Other (specify)** ________________________________

(OVER)

REVIEW OF SYSTEMS *** (*this information pertains to* *__patient only;__* *check all that apply*):

EARS: ☐Hearing Loss ☐Tinnitus (noise in ears) ☐Hearing comes and goes ☐Balance problems ☐Dizzy (Vertigo) ☐Pain ☐Drainage ☐Recurrent infection ☐Hole in ear drum ☐Fluid in ears ☐Wax Impaction ☐Exposure to Loud Noise ☐Hearing Aids ☐Other____________________

NOSE: ☐Difficulty breathing ☐Stuffiness ☐Clear nasal drainage ☐Discolored nasal drainage ☐Recurrent infection ☐Post Nasal Drip ☐Sneezing ☐Snoring ☐Noisy breathing ☐Change in smell ☐Bleeding ☐Injuries ☐Deformity ☐Deviated septum ☐Polyps ☐ Sense of smell ☐Other _________________________

THROAT: ☐Pain ☐Difficulty Swallowing ☐Painful Swallowing ☐Voice changes / hoarseness ☐Chronic Cough ☐Sensation of lump in throat ☐Frequent throat clearing ☐Choking or strangling sensation ☐Recurrent Infection ☐Enlarged Tonsils ☐Tonsillitis ☐Other_____________________

MOUTH: ☐Mouth breathing ☐Bad breath/ Foul Odor ☐Bad taste ☐Oral lesion ☐Sleep Apnea ☐Tongue Tied ☐Other___________________

NECK: ☐ Mass/lump ☐Swollen glands ☐Pain ☐Injuries ☐Thyroid nodules ☐Other________________

HEAD & FACE: ☐ Skin Lesions ☐ Persistent headaches ☐ Facial pain/pressure ☐ Injuries ☐ Other ____________________________

GENERAL: ***If you currently have or have had medical problems in the following areas please check and provide explanation***

- ☐ Diabetes ______________________________ ☐ High blood pressure________________________________
- ☐ Cancer ______________________________ ☐Hypo/Hyperthyroidism ______________________________
- ☐ Eyes ____
- ☐ Heart/Vascular ____
- ☐ Breathing/Respiratory____
- ☐ Stomach/Intestinal ____
- ☐ Urinary/Kidneys____
- ☐ Muscles / Bones ____
- ☐ Skin ____
- ☐ Neurological____
- ☐ Mental Health/Psychiatric____
- ☐ Blood/Immune System____
- ☐ Endocrine/Lymph System____
- ☐ Other ____

NAME OF PHARMACY AND LOCATION: ____

Is there anything else about your medical history or current condition that might be helpful for the doctor to know? (please specify)

____

____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

PATIENT/GUARDIAN SIGNATURE: _______________________________________ **DATE:** _____________

PHYSICIAN SIGNATURE: ____

MEDICATION LIST

JOSEPH H. BERGER M.D.

Patient Name:____ Date:____________________________

List medications, (including over-the-counter) and Nose Sprays		Strength (mg) and Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _________________________, understand that as part of my healthcare, [JOSEPH BERGER M.D./NATHAN RHODES AU.D.] originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services built were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed, to carry out treatment, payment, or healthcare operations

I understand that [JOSEPH BERGER M.D./NATHAN RHODES AU.D.] are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 16 4.506 of the Code of Federal Regulations.

I further understand that [JOSEPH BERGER M.D./NATHAN RHODES AU.D.] reserve the right to change their notice and practices and prior to implementation, in accordance with section 16 4.520 of the Code of Federal Regulations. Should [JOSEPH BERGER M.D./NATHAN RHODES AU.D.] change their notice, they will send a copy of any revised notices to the address I've provided (whether U.S. Mail or if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or healthcare options, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

I hereby authorize the physicians or staff of Joseph H. Berger M.D. LLC / South Georgia Audiology & Hearing Center:

- **to furnish any information required to process my insurance claims, and I hereby assign all payments directly to Joseph H. Berger M.D. for medical services rendered to my dependents or self.**

- **to leave appointment reminders on my answering machine or voicemail.**

- **Any financial or medical information to the following individuals (listed):**

  ____

  ____

  ____

The Federal Trade Commission (FTC) has released a new rule to protect consumers from **IDENTITY THEFT**, which is now becoming known as the "**Red Flag Rule**". As a result, Joseph Berger M.D. and South Georgia Audiology & Hearing Center will now require a copy of your:

1. Drivers license or state issued form picture identification.
2. Proof of insurance.

I fully understand and **ACCEPT** the terms of this consent _______

I fully understand and **DECLINE** to the terms of this consent ________

Patient Signature:____ **Date:**___________

FOR OFFICE USE ONLY

[ ] consent received by__________________________________ on_________________________.

[ ] consent refused by patient, and treatment refused as permitted.

[ ] Consent added to patient's medical record on_______________________.