PLEASE LIST THREE CONTACT NUMBERS!

Patient's Last Name _____ First Name_____ Middle Initial ____

Date of Birth _____ Age _____ Sex: F M

Address _____ City _____ State _____ Zip _____ County_____

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

Home Phone _____ Day Phone _____ Cell Phone _____

Employer: _____ occupation? _____ ☐ Retired?

Spouse/Parent/Legal Guardian _____

Primary Medical Insurance- Information needed in order to File Insurance

Aetna
BCBS
BCBS Pathway X
Cigna
Medicare
Medicaid
Taylor Benefit
Other_____

Policy holder name:_____d.o.b._____

2nd ins_____

Emergency Contact: _____ Phone #: _____

Referring by Physician_____ **Internet ____ Face Book ___ Website___ Friend___ TV ___**

Family physician:_____

To allow for more efficient scheduling we require a 24 hour cancellation notice for OFFICE VISITS. In the event this is not met, a $50.00 fee will be charged to your account. No show without a 24 hour notice -$100 charge for PROCEDURES & TEST. (ONE) week cancellation notice for all SURGERIES. In the event this is not met, you will be charged a ($200.00) fee.

_____
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: H**ave 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		

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

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Joseph Berger, M.D., and South Ga Audiology & Hearing Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Joseph Berger, M.D.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Joseph Berger, M.D., and South Ga Audiology & Hearing Center reserve the right to revise its Notice of Privacy Practices at anytime.

With this consent, Joseph Berger, M.D., and South Ga Audiology & Hearing Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I authorize the release of any financial or Medical information to the following individuals (listed below).

_____

_____

The Federal Trade Commission (FTC) has released a new rule to protect consumers from Identity Theft, "Red Flag Rule". Dr. Berger will now require a copy of your Drivers License or state issued form of identification with picture. Also, proof of Insurance.

I fully understand and accept the terms in this consent.

_____ Date:_____

Signature of Patient or Legal Guardian