

Circle one: Mr. Mrs. Ms. Miss

Patient First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Circle one: Home Cell Phone

Secondary Phone: \_\_\_\_\_ Circle one: Home Cell Phone

Email Address: \_\_\_\_\_ @ \_\_\_\_\_

Marital Status (circle one): Married Single Widowed Ethnicity: \_\_\_\_\_

Patient Social Security No: \_\_\_\_\_

Date of Birth: MM/\_\_\_\_DD/\_\_\_\_YEAR/\_\_\_\_ Age: \_\_\_\_\_ Sex (circle one): M F NA

Employer Name: \_\_\_\_\_ Circle one: Full-time Part-time

Employer Address: \_\_\_\_\_

Number of Employees (circle one): 0-20 21-99 100 or more

Emergency Contact: \_\_\_\_\_ Phone: \_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Name of Physician or other source who referred you to our practice:

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

### Responsible Party (If other than patient)

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Circle one: Home Cell Phone

Date of Birth: MM/\_\_\_\_DD/\_\_\_\_YEAR/\_\_\_\_ Social Security No: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Circle one: Full-time Part-time

Employer Address: \_\_\_\_\_

Number of Employees (circle one): 0-20 21-99 100 or more

### Insurance Information

Primary Insurance Co: \_\_\_\_\_ Phone: \_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_

Date of Birth: MM/\_\_\_\_DD/\_\_\_\_YEAR/\_\_\_\_ Social Security No: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Circle one: Full-time Part-time

Secondary Insurance Co: \_\_\_\_\_ Phone: \_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

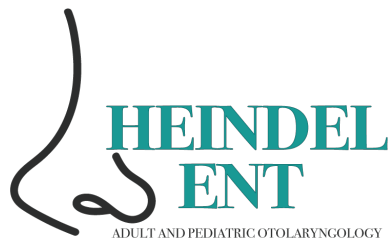
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_

Date of Birth: MM/\_\_\_\_DD/\_\_\_\_YEAR/\_\_\_\_ Social Security No: \_\_\_\_\_



## Request for Release of Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Please print the facility or doctor name, phone number, address, and fax number from which Heindel ENT is requesting records:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please send medical record request to the following (fax is the preferred delivery method for medical records):

Heindel ENT  
2080 Newnan Crossing Blvd. Suite 300  
Newnan, Georgia 30265

Phone: 770-955-0270

Fax: 770-955-0271



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

## Health History

Welcome to Heindel ENT. As a new patient, please provide the information listed below to the best of your ability.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

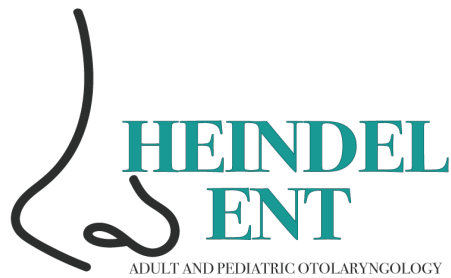
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reasons for today's visit: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_

<p><b>Medications (please list):</b></p>	<p><b>Allergies to Medications:</b></p>
<p><b>General Medical History:</b></p>	<p><b>Surgical History:</b></p>
<p><b>Smoking Status (please choose one):</b></p> <p><input type="checkbox"/> Current everyday smoker</p> <p><input type="checkbox"/> Current someday smoker</p> <p><input type="checkbox"/> Former smoker</p> <p><input type="checkbox"/> Never smoked</p> <p><input type="checkbox"/> Unkown if ever smoked</p> <p><input type="checkbox"/> VAPE or Smokeless Tobacco</p> <p><b>Started smoking:</b> mm/dd/yyyy _____</p> <p><b>Quit smoking:</b> mm/dd/yyyy _____</p> <p><b>Number of packs per day:</b> _____</p> <p><b>Total years smoking:</b> _____</p>	<p><b>Influenza:</b> <b>Have you had your flu shot this year?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>If no, why?</b> _____</p> <p><b>Covid History:</b> <b>Have you ever had the Covid vaccine and boosters?</b> <b>(if you are 65 years or over)</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>If no, why?</b> _____</p>



## Financial Responsibility

A deductible is a specified portion of your bill that a patient must pay before an insurance company will pay his/her claim. While, generally, a co-payment is required for an office visit, some services and all procedures performed in the office will require the patient to meet the deductible before any benefits will be paid. If your deductible has not been met, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery by insurance companies and are billed as such.

Additionally, your office visit today, and/or in the future, may include the use of a scope for diagnostic purposes. This is considered a diagnostic procedure, which will likely be coded to your insurance company as a **SURGICAL PROCEDURE**. Depending on your particular policy, your insurance company will pay all, part, or none of the cost of this procedure. It is your responsibility to be aware of the terms and conditions of your policy prior to the procedure being performed. Any charges not covered by the insurance carrier will be the responsibility of the patient.



### **YOU HAVE THE RIGHT TO REFUSE THIS DIAGNOSTIC PROCEDURE.**

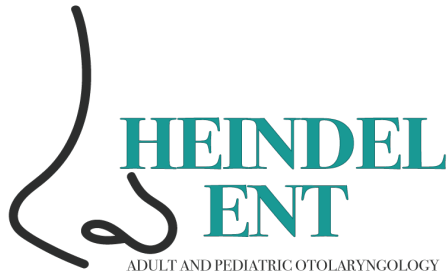
By signing this consent form, you are acknowledging these terms.

**INSURANCE INFORMATION:** I acknowledge that the physician(s) of Heindel ENT may not be a part of the provider network for my insurance plan. I understand that it is my responsibility to verify this information with my insurance company.

In order to keep our charges as low as possible, we expect payment for services, deductible, co-insurance and co-pay at the time of service unless arrangements have been made in advance with the business manager. I will pay my portion of the services today by one of the following: Cash, Check, or Credit Card.

I hereby authorize the physician(s) of Heindel ENT to furnish the necessary information concerning my illness and treatment to my insurance company, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by my insurance. My signature will also serve as authorization to treat my child if the patient is a minor.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Relationship** \_\_\_\_\_



## **Appointment Cancellation Policy**

As a courtesy, we agree to confirm your visit one week before your scheduled appointment. You will at that time have the opportunity to confirm or cancel the scheduled appointment. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not cancelling their scheduled appointment is that the physician is then unable to accommodate those patients with sudden medical problems that require medical intervention.

Please call us at (770)-955-0270, Extension 1, by 2:00 p.m. on the day prior to your scheduled appointment to notify the office staff of any changes or cancellations.

To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

**If prior notification is not given, you will be charged a fee of \$90 for the missed appointment.**

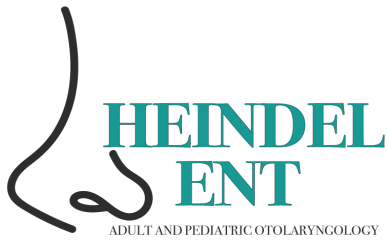
I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide the required cancellation notice of any scheduled appointments at Heindel ENT. I understand that this fee is not reimbursable by my insurance provider.

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**Signature of Patient or Authorized Person**

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**Date**



## Health Insurance Portability & Accountability Act (HIPAA)

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of home.

It is Heindel ENT's policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail and/or cell phone. However, we will confirm appointments by telephone.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

Yes  No

2. May we discuss your medical information with family & friends?

Yes  No

Please list names of people with whom we can discuss your medical care:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Patient's relationship to contact: Spouse  Parent  Child  Friend

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Patient's relationship to contact: Spouse  Parent  Child  Friend

### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read or had the opportunity to read this document. I understand the Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_

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

Patient Printed Name: \_\_\_\_\_

Parent or Authorized Representative (if applicable): \_\_\_\_\_