ENT Specialists of Metairie
Ear, Nose & Throat | Audiology, Allergy & Sleep

Michael Hickham, MD
Paul M. Spring, MD

PATIENT INFORMATION AND INSURANCE

Legal First Name: _____ MI: _____

Legal Last Name: _____

Nickname: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Social Security #: _____

Gender: ☐ Male ☐ Female

Race:
☐ Asian ☐ African Am ☐ Hispanic ☐ White ☐ Other

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Primary Language: ☐ English ☐ Spanish

Other: _____

Employer: _____

Occupation: _____

Work Phone: _____

Referred by: _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Emergency Contact: _____

Phone Number: _____

Relationship: _____

Primary Insurance:

_____

Insured by: ☐ Self ☐ Parent ☐ Spouse
☐ Other: _____

Insured Information (if not the patient) / Guarantor

First Name: _____

Last Name: _____

Date of Birth: _____

Social Security Number: _____

Secondary Insurance: _____

Do you have a living will? ☐ YES ☐ NO

ACKNOWLEDGEMENT: *I have reviewed the above information and verify that it is correct. I request payment of authorized insurance/Medicare benefits be made on my behalf to ENT Specialists of Metairie for any services furnished me by that provider. I authorize any holder of medical information about me to release to my insurance carrier/CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits are payable for related services. I understand I am financially responsible for any benefits not covered/payable by my insurance.*

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice
Dr. Hickham and Associates

Patient's Name: _____

Social Security Number: _____

This acknowledges that I was given a copy of this Notice of Privacy Practices. I have read the Notice or had the information in the Notice explained to me.

At any time, another copy of the Notice may be requested by contacting this office. Our Notice of Privacy Practices explains how we will use and/or disclose your health information.

Patient's Signature: _____ Date: _____

Name of employee (Print): _____

Signature of Employee: _____

FOR OFFICE USE ONLY:

If the patient does not sign this acknowledgement, give the reason and document your good faith efforts to obtain the written acknowledgement.

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

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Communication Preference Form

Patient Name (please print) _____

Date of Birth _____

Please indicate which of the following numbers you would like to use:

☐ Home Phone: (_____) _____ - _____

☐ Work Phone: (_____) _____ - _____

☐ Cell Phone: (_____) _____ - _____

Email _____

Please note, if you supply a cellphone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out if you wish.

What is your preferred communication method? ☐ Email ☐ Phone

We don't currently have the ability to provide communication via text messaging, but should this option become available, would you like to opt in? ☐ Yes ☐ No

Unless specific permission is granted, we will not release medical information to anybody other than you. Should you wish to allow another individual access to your medical information, please identify by name and relationship to you (e.g., spouse, parent, nursing home, caregiver, etc.):

☐ Do **not release medical information** to anyone other than myself.

☐ I give permission to release medical information pertaining to me to the individuals listed below.

Name	Relationship (e.g., spouse, parent, nursing home, caregiver, etc.)	Phone Number

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____

Signature Date

_____

(Please Print Name)

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Cancellation & No-Show Policy

Cancellations:

If our patients are unable to keep their appointment, we appreciate a call 24-hours in advance. This allows ENT Specialists of Metairie to schedule and service other patients.

Canceling an appointment with less than 24-hour notice impacts ENT Specialists of Metairie and the opportunity to service other patients. We understand that sudden emergencies of life that require cancellation of your appointment. Therefore, we have developed a policy that is sensitive to our patient's lives and enforces a policy based on not just one cancellation, but two (2) cancellations.

In the case of two (2) consecutive cancellations with less than 24-hour notice, we reserve the right to charge a cancellation fee of up to 50% of the cost of the scheduled appointment. We also reserve the right to ask the patient to provide a credit card to book future appointments.

No-Shows:

More than two (2) consecutive No-Shows will be handled the same as cancellations. We reserve the right to charge a No-Show fee of up to 50% of the cost of the scheduled services, to ask the patient to provide a credit card to book future appointments, and to charge that credit card the No Show fee as outlined in this policy prior to future appointment scheduling.

Patient Name	Patient Signature	Date

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REVIEW OF SYMPTOMS

Patient Name: _____ Date: _____

Do you now or have you in the past had any problems related to the following?

PLEASE CHECK ALL THAT APPLY

CONSTITUTIONAL
- ☐ Chills
- ☐ Fever
- ☐ Unintended Weight Loss
- ☐ Malaise
- ☐ Night Sweats

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur
- ☐ High-Blood Pressure

HEMA/LYMPH
- ☐ Bleeding Tendency
- ☐ Blood Clotting Problem
- ☐ Easily Bruised
- ☐ Swollen Glands

MUSCULOSKELETAL
- ☐ Weakness
- ☐ Pain
- ☐ Arthritis

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Paranoia
- ☐ Delusions

EARS
- ☐ Pain
- ☐ Itching
- ☐ Pressure
- ☐ Popping
- ☐ Ringing
- ☐ Tubes
- ☐ Discharge
- ☐ Vertigo/ Dizziness
- ☐ Frequent Infections
- ☐ Bleeding
- ☐ Hearing Loss: R / L

NOSE / EYES
- ☐ Trauma
- ☐ Obstruction
- ☐ Discharge
- ☐ Drip
- ☐ Snoring
- ☐ Sneezing
- ☐ Bleeding
- ☐ Headache
- ☐ Loss of Smell
- ☐ Facial Pain
- ☐ Frequent Dry Eyes
- ☐ Blurred Vision
- ☐ Doubled Vision
- ☐ Pain
- ☐ Cataracts
- ☐ Itching

THROAT
- ☐ Difficulty Swallowing
- ☐ Soreness
- ☐ Frequent Infections
- ☐ No Teeth
- ☐ Ulcers

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Bloody Stool
- ☐ Reflux

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Excessive Thirst
- ☐ Hair loss

SKIN
- ☐ Rash
- ☐ Growth
- ☐ Skin Cancer
  Site: _____

ADDITIONAL ROS
- ☐ Neck Pain
- ☐ Neck Mass

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic Coughing
- ☐ Wheezing
- ☐ Coughing Blood

GENITOURINARY
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Inability to Empty Bladder

IMMUNOLOGIC/ ALLERGY
- ☐ Hay Fever
- ☐ Food Intolerance
- ☐ Insects
- ☐ Chemicals

NEUROLOGIC
- ☐ Numbness
- ☐ Paralysis / Paresis
- ☐ Headaches
- ☐ Dementia
- ☐ Alzheimer's

Patient Signature: _____ Date: _____

Drug Allergies	List of Medications	Past Surgical History

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HOW TO DETERMINE IF YOU HAVE SINUSITIS

Because sinus symptoms are similar to those of allergies and the common cold, it is often difficult to determine if the pressure, pain and dizziness you are experiencing are the result of chronic sinusitis. To help you determine which sinus treatment is the right solution for your symptoms, please answer the questions below.

Circle "yes" if any of the following symptoms have persisted for 10 days or longer:

Facial pressure or pain	YES	NO
Headache	YES	NO
Congestion or stuffy nose	YES	NO
Thick, yellow-green nasal discharge	YES	NO
Low-grade fever (99-100 degrees)	YES	NO
Bad breath	YES	NO
Pain in your teeth	YES	NO

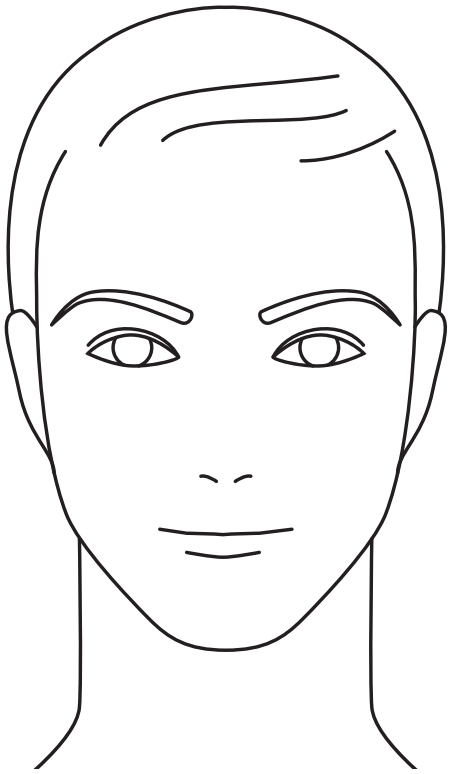
DURATION AND FREQUENCY

Have you experienced these symptoms for longer than 12 consecutive weeks?	YES	NO
Have you experienced these symptoms for 10 or more days at least four times in the last twelve months, with symptom-free periods in between?	YES	NO

If you answered "yes" to three or more of these questions and either the extended duration or repeated frequency questions, you may be suffering from chronic or recurrent sinusitis. We urge you to consult an ear, nose and throat specialist for an examination.

Be sure to ask your provider about balloon sinus dilation, a minimally invasive treatment option that can bring relief to patients who have not had success with other treatments.

If you have facial pain or pressure, please indicate on the face below where you are experiencing that pain or pressure.



Please rate your current facial pain / pressure on a scale of 1 to 5, with 1 indicating no pain and 5 being severe pain.

1	2	3	4	5
No pain				*Severe pain*

When did you first start experiencing these symptoms? _____

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation:

0 = would never

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (theater, meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

TOTAL _____

☐ Witnessed Apnea ☐ Excessive Daytime Sleepiness ☐ No Thyroid History ☐ Snoring