COMPREHENSIVE EAR NOSE THROAT ALLERGY SINUS LLC

Dean R. Lindstrom III, MD Jenna Irving, ARNP

PATIENT INTAKE FORM

Patient name:_____DOB:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell:_____

Email:_____ Sex (circle): Male Female

Preferred way of contact (please circle): Home phone Cell Phone Email

Primary Care Physician: _____Referring Provider:_____

Race (circle): White Hispanic Black (other) Ethnicity: Hispanic Not Hispanic Language:_____

Emergency Contact & Phone: _____

INSURANCE INFORMATION

Primary carrier: _____

Policy ID:_____Group:_____

Policy Holder name/DOB/relation(if not patient)_____

Secondary Carrier:_____

Policy ID: _____Group:_____

Policy Holder name/dob/relation:_____

Responsible Party: _____Relation:_____

I request care from Comprehensive Ear Nose Throat Allergy Sinus LLC/Dean Lindstrom, MD/Jamie Crawford, NP for treatment of my medical condition. This may include tests, exams or other treatments needed for my condition. I agree to have my insurance company make payments directly to this provider and for this provider to submit claims for my required treatment to my insurance company. I understand that I am responsible for all charges deemed my responsibility by my insurance carrier. I also understand that it is necessary to communicate information to my Primary Care/Referring Provider and may include information about my medical treatment.

Signature of Patient:_____Date:_____

Dr. Lindstrom
ENT
SINUS CARE CENTER OF BREVARD
COMPREHENSIVE EAR, NOSE, THROAT, ALLERGY & SINUS
1314 PINE STREET – MELBOURNE, FL 32901
PHONE: (321) 802-6697 FAX: (321) 802-3158

HEALTH HISTORY FORM

Patient Name:_____ DOB: _____

Reason for Visit: _____

Hgt: _____ Wt: _____Pharmacy:_____

Please list **ALL** medications (prescription & non-prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs etc.)

Please specify if medications are "As Needed" if applicable

Medication	Medication	Medication	Medication

Do you take any **BLOOD THINING** products such as Vitamin E, Plavix, Eliquis, Coumadin or Aspirin? _____ **No** _____ **Yes**

Medical History: Please list ALL medical diagnoses (i.e. High Blood Pressure, Sinusitis, Thyroid Disease), including those you are currently on and not on medication to. Also include medical devices (i.e. CPAP machines used) below

Medical History	Medical History

Do you have any food, environmental, or drug allergies? _____ **N.K.D.A** _____ **Yes (please explain below)**

Allergy	Reaction

Surgeries	**Dates**	**Hospitalizations**	Dates

Please list family medical history below. Include history of cancer (please specify type), diabetes, heart disease, etc.

Family History	**Deceased/Alive**	**Age**	**Illnesses**	**Cause of Death**
Mother				
Father				
Siblings				

Social History:

Who do you live with? _____ Marital Status: Single Married Divorced Separated Widowed

Second hand smoke exposure (now or in the past)? _____ Yes _____ No

Pets: _____

Occupation: _____ Retired? _____ Yes _____ No

Do you drink alcohol? _____ No _____ Socially only _____ Daily
_____ Beer/Wine _____ Hard Liquor

Do you smoke? _____ If so, **every day** or **somedays** (please circle)

How much do you smoke? (# of cigarettes) _____

If 'current smoker': Are you interested in quitting? (please circle) Ready to quit, thinking about quitting or not ready to quit

Did you smoke in the past? _____ If so, how long ago? _____

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Dean Richard Lindstrom III, MD
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Melbourne, FL 32901
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AUTHORIZATION TO USE/DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Patient Name:_____DOB:_____

I, _____ authorize Comprehensive Ear Nose Throat Allergy Sinus LLC/Dean R. Lindstrom III, MD to use or disclose my entire medical record, treatment, and/or test results to the individual(s) listed below. I understand that I do not have to choose a person to receive my medical information and I give my authorization voluntarily.

Name: _____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

_____I DO NOT want anyone but MYSELF to receive my medical information

- I understand I may revoke this authorization at any time, provided I do so in writing except to the extent that action has been taken in reliance upon this authorization.
- I understand that **Comprehensive Ear Nose Throat Allergy Sinus LLC/Dean R. Lindstrom III, MD** will not condition my treatment or payment for treatment on whether I provide authorization for the requested use or disclosure.
- This authorization will remain in effect from the date of my signature below for the period of 10 years, unless revoked by me in writing.

_____I authorize **Comprehensive Ear Nose Throat Allergy Sinus LLC/Dean R. Lindstrom III, MD to leave NORMAL TEST RESULTS on my answering machine/voicemail.**

Home Phone:_____Cell Phone:_____

Patient Name (PRINT):_____

Patient/Authorized signature:_____

Relationship:_____DATE:_____

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FINANCIAL POLICY

What Is My Financial Responsibility for Services Rendered?

It is your responsibility to verify that the physicians is an authorized provider under your insurance plan. Self pay appointments are required to pay at time of visit. In the event that you have not made any payment within 120 days of your first statement, you will be transferred to outside collections where the additional charge of a minimum of $25.00 will be added.

Medical records are forwarded to your PCP within 1-2 days from your visit here. If you request a copy of your medical record from our office, there is a Medical Records Processing fee of $10.00 and .25 cents per page.

Surgery

Your financial responsibility will be determined by an estimation as received by your insurance company. You will be asked for a portion of your responsibility prior to surgery. Once claim is filed, you will receive either a refund or statement. If you willingly cancel less than 24 hours prior to surgery or miss your surgery, you will be charged a fee of $250.00 or $500.00

No Show/Missed Appointment

This office and Dr Lindstrom is committed to your wellbeing and has reserved time just for you. "No Shows" and "Late Cancellations" waste the doctors limited appointment availability and adversely affect the care provided to our patients. If you are not able to make your appointment and do not call and speak to a staff member, you will be charged a $50.00 missed appointment fee. If you have missed your third appointment the fee is then $75.00. Leaving a message on the after hours line is not acceptable notice. This notice must be at least 24 hours prior to your scheduled appointment. Same day cancellation/reschedule will be charged a fee of $50.00 and discharge rules remain the same for same day cancellations/reschedules made by patient.

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Please note that three no show appointments, three consecutive cancellations/reschedules or more than 5 cancellations/reschedules in a calendar year will lead to a discharge from our practice.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and coinsurances, are my responsibility. I fully understand office policies for late cancellation/reschedule/no show fees and understand I may be discharged from practice.

I authorize Comprehensive Ear Nose Throat Allergy Sinus, LLC and Dr Lindstrom to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Comprehensive Ear Nose Throat Allergy Sinus, LLC.

Please make sure you are very aware of our "NO SHOW" and "LATE CANCELLATION" Policy on the previous page. This fee is Non-Negotiable and leaving the information on the answering service prior to your appointment is NOT acceptable. Our providers make every effort to maintain priority care for all of our patients and we rely heavily on our scheduling availability.

_____ _____ _____
Date **Signature of Patient/Guardian** **Printed Name**

_____ _____ _____
Date **Signature of Employee** **Printed Name**

Patient was given the original to take home.