BLUEGRASS EAR, NOSE, AND THROAT

ALBERT SPEACH, M.D.
3080 HARRODSBURG SUITE 200 LEXINGTON,KY 40503

PATIENT INFORMATION:

REFERRING PHYSICIAN_____

LAST NAME_____FIRST NAME_____M.I.____

ADDRESS_____CITY_____ST____ ZIP_____

HOME PHONE_____CELL_____

EMPLOYER_____WORK PHONE_____

DOB_____SEX_____SOCIAL SECURITY #_____MARITAL STATUS_____

RACE: (X) AMERICAN INDIAN OR ALASKAN____ CAUCASIAN____ BLACK____ ASIAN____ OTHER____

ETHNICITY: (X) HISPANIC____ NON-HISPANIC____

LANGUAGE: (X) ENGLISH____ ARABIC____ SPANISH____ FRENCH____ JAPANESE____ OTHER____

EMAIL CONTACT (OPTIONAL)_____

HAVE YOU OR ANY FAMILY MEMBER BEEN SEEN BY DR SPEACH BEFORE? YES/NO
PLEASE LIST NAME_____

INSURANCE INFORMATION:

INSURANCE COMPANY_____

ID#_____GROUP#_____

INSURED LAST NAME_____ FIRST NAME_____ M.I._____

RELATIONSHIP TO PATIENT_____

DATE OF BIRTH_____ SEX_____ SOCIAL SECURITY #_____

ADDRESS_____CITY_____ST___ZIP_____

HOME PHONE_____CELL PHONE _____

EMPLOYER_____WORK PHONE_____

EMERGENCY CONTACT INFORMATION:

LAST NAME_____FIRST NAME_____M.I.____

RELATIONSHIP TO PATIENT_____

HOME PHONE_____WORK PHONE_____

CELL PHONE_____

PHARMACY INFORMATION:

NAME_____ PH_____

Please read, initial, and sign at the bottom regarding notification of the following:
(YOU MUST INITIAL BESIDE EACH ONE AND SIGN AT THE BOTTOM)

_____I have informed Dr. Speach of the patient's medical history including medical conditions such as diabetes, high blood pressure, bleeding disorders, and/or latex allergies and have also given him a complete list of medications that the patient takes on a daily and/or as needed basis. I understand this information is crucial to the patient's quality of care and that withholding information (either deliberately or mistakenly) may put the patient at higher risk for complications with medical treatment.

_____ I have disclosed to Dr. Speach if the patient has been diagnosed with any blood-borne/infectious diseases such as but not limited to Hepatitis and/or HIV/AIDS. I have also disclosed if the patient is at high-risk for blood-borne/infectious disease including hospital/medical worker, prior blood transfusion, history of IV drug use, and/or homosexual relationship. I understand it is the patient's/guardian's responsibility to inform Dr. Speach of such diagnoses or risk factors for blood-borne/infectious disease and the failure to do so (either deliberately or mistakenly) violates the doctor/patient contract

_____I understand that failure to disclose any aspect of my medical history or risk factors for blood-borne disease (either deliberately or mistakenly) may result in the discharge of the patient from Dr. Speach's care.

_____I understand that I am responsible for any co-insurance, deductibles, co-payments, and/or out-of-pocket expenses determined by my insurance carrier. This includes services that my insurance carrier deems "not-covered" or "out-of-network", and services that are obtained without primary care physician referral when required. **All office visit co-payments are required the day of service**. It is the patient's/subscriber's responsibility to know their benefits, to obtain referrals when required, and to verify, before services are rendered, if Bluegrass Ear, Nose, and Throat is considered in network with their insurance. If you have any questions regarding your benefits, you need to call the customer service phone number located on the back of your insurance card. I also authorize payment from my insurance carrier directly to Albert Speach, MD for medical claims filed on patient's behalf.

(Bluegrass ENT participates with Medicare, Medicaid, Kenpac (**with Primary Care Referral**), Anthem/BlueCross, Humana, United Healthcare, Bluegrass Family Health, Tri-Care Standard (**not Prime**), Cigna, PHCS and Aetna (**some plans require referral and this must be obtained to get full benefit payments**).

_____I authorize the release of medical information to/from other physicians, hospitals and insurance companies.

_____I have received and read the HIPAA compliant release of medical information and privacy practices from Bluegrass Ear, Nose, and Throat.

_____ _____

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, OR EMERGENCY CONTACT DATE

_____
PRACTICE REPRESENTATIVE

Please indicate all past and present medical history and the dates of any surgical procedures if known.

GENERAL HISTORY

Age_____
Ht. _____
Wt._____

MEDICATION LIST (TYPE, STRENGTH, DOSAGE)

_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS AND THEIR REACTIONS

_____
_____
_____
_____
_____
_____

ENT HISTORY

____ Bleeding Problems
____ Anesthesia Problems
____ Seasonal Allergies
____ Hearing Loss
____ Acid Reflux
____ Sleep Apnea
____ Meniere's Disease

MEDICAL HISTORY

____ Heart Disease/ Heart Attack_____
____ Stroke/Vascular Disease_____
____ High Blood Pressure
____ Diabetes
____ Cancer (indicate location)_____
____ Thyroid Disease
____ Asthma
____ COPD/emphysema
____ Kidney Disease/Problems
____ Seizure Disorder
____ Stomach Ulcer
____ Spine Problems
____ Hepatitis
____ HIV/AIDS
____ Other _____

SURGICAL HISTORY

____ Sinus Surgery (date) _____
____ Tonsil/Adenoid Surgery (date) _____
____ Ear Tubes (date) _____
____ Thyroid Surgery (date) _____
____ Parathyroid Surgery (date) _____
____ Eardrum Repair (tympanoplasty) _____
____ Mastoidectomy/Mastoid surgery _____
____ Cardiac Angioplasty (date) _____
____ Cardiac Bypass (date) _____
____ Heart Valve Replacement (date) _____
____ Carotid Endarterectomy (date) _____
____ Joint Replacement (date) _____
____ Stomach Surgery (date) _____
____ Gallbladder (date) _____
____ Appendix (date) _____
____ Prostate (date) _____
____ Hysterectomy (date) _____
____ Eye/Lasik/Cataract (date) _____
____ Other _____
_____

SOCIAL HISTORY

Most Recent Primary Occupation _____
____Tobacco Use (____Packs/Day x_____Years)
____Alcohol Use (____Drinks/Day)
____ Second Hand Smoke Exposure x _____ Years
____Illicit Drug Use (Type_____)
____Caffeine (____Cups/Day)

FAMILY HISTORY
(List relationship to patient)

____ Heart Disease/ Heart Attack_____
____ Stroke/Vascular Disease_____
____ High Blood Pressure
____ Diabetes
____ Cancer (indicate location)_____
____ Thyroid Disease
____ Asthma
____ COPD/emphysema
____ Kidney Disease/Problems
____ Seizure Disorder
____ Stomach Ulcer
____ Spine Problems
____ Other _____
_____
_____