HEALTH HISTORY

Name ______________________ Date of Birth ______________________

Date ______________________ Pharmacy ______________________

Current Medications (including prescriptions, over the counter drugs and supplements)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Do you take aspirin? ❑ YES ❑ NO
Are you allergic to any medications? ❑ YES ❑ NO If yes please list below.

______________________ ______________________

What was your reaction? (rash, hives, anaphylaxis, shortness of breath, etc.)

____

List Food & Environmental Allergies

____
____
____

Have you ever had surgery? ❑ YES ❑ NO
If yes please list below.

____
____
____

Hospitalization/Accidents Illness? ❑ YES ❑ NO
If yes please list below.

____
____
____

Do you have any pins, screws or plates? ❑ YES ❑ NO

General Medical History

Have you ever had:	Yes	No
AIDS or HIV	❑	❑
Asthma or any lung problems	❑	❑
Bleeding Tendency	❑	❑
Blood or Plasma Transfusion	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Drug Addiction	❑	❑
Heart Disease/Mitral Valve	❑	❑
Heart Surgery	❑	❑
Pacemaker	❑	❑
Hepatitis or Cirrhosis	❑	❑
High Blood Pressure	❑	❑
Kidney Disease	❑	❑

Have you ever had:	Yes	No
Stomach Ulcer	❑	❑
Tuberculosis	❑	❑
IV Contrast Reaction	❑	❑
Multiple Sclerosis	❑	❑
Cystic Fibrosis	❑	❑
Muscular Dystrophy	❑	❑
Seizures	❑	❑
MRSA	❑	❑

Social History

	Yes	No	How much
Alcohol Use	❑	❑	________
Caffeine Use	❑	❑	________
Tobacco Use	❑	❑	________
Substance Use / Recreational Use	❑	❑	________

Family History

	Yes	No	Who?
Heart Disease	❑	❑	________
Cancer	❑	❑	________
High Blood Pressure	❑	❑	________
Stroke	❑	❑	________
Seizures	❑	❑	________
Thyroid Disease	❑	❑	________
Bleeding Tendencies	❑	❑	________
*Anesthesia Complications	❑	❑	________

*Please explain ______________________

Referred by: ______________________

If due to an accident: Date of accident ____________ Where and how accident occurred ______________________

____

Signature ______________________

GRAND ISLAND EAR, NOSE AND THROAT CLINIC
PATIENT REGISTRATION FORM

Patient Name: ______________________________ Maiden Name: ____________
Address: ____
City/State/Zip ____
Social Security Number: ____________________ Drivers License # ____________
Sex: Male _____ Female _____ Birth Date: __________________ Age: _______
Marital Status: Single Married Divorced Widowed Race: _______________
Home Phone: ____________________ Cell Phone: ___________________
Cell Phone Provider: ____
Employer: _____________________________ Work Phone _________________
Family Physician: _________________________ Referred by: _____________

If Married:

Spouse's Name: ______________________________ Birth Date: ___________
Social Security# _________________________ Cell Phone ________________
Employer: _________________________________ Work Phone _____________

If Patient is a Minor:

Mother's Name: _____________________________ Birth Date: ____________
Social Security # ____________________ Cell Phone _____________________
Employer ____________________________ Work Phone _________________
Drivers License Number: ____
Father's Name: ______________________________ Birth Date: ____________
Social Security # ____________________ Cell Phone _____________________
Employer ____________________________ Work Phone _________________
Drivers License Number: ____

Emergency Contact:

Name: _________________________________ Relationship _______________
Phone Number ____________________________ Cell Phone ________________

Name of Insurance Company:

Subscriber's Name ____
Date Of Birth ____________________ Social Security #: ____________________
Subscriber's Employer ____

PLEASE BRING INSURANCE CARDS FOR PHOTOCOPYING. THANK YOU

I certify this information is true and correct to the best of my knowledge. I authorize the release of all medical information to my primary care physician, insurance provider or any other health care provider and request that payment of benefits be made to the physician. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature: _____________________________________ Date: ______________

Grand Island Ear, Nose & Throat Clinic

MEDICATION FLOW SHEET

PATIENT NAME: ______________________________ **D.O.B:** ____________________

PHARMACY: ______________________________ **NKMA:** ____________________

x-Start **→ Continue** **DC = Medication Stopped** **S = Samples**

MEDICATION	DATE(S) ASSESSED										
****Date ***											

G.I. EAR, NOSE & THROAT, P.C.
704 NORTH ALPHA STREET
GRAND ISLAND, NEBRASKA 68803
Telephone (308) 384-5700
Fax (308) 384-4305

THOMAS S. NABITY, M.D.
KIMBERLY L. JOYNT, D.O.

EAR NOSE THR
HEAD NECK SURG
FACIAL PLASTIC SURG

Financial Policy for Grand Island Ear, Nose and Throat Clinic

As a patient of **The Grand Island Ear, Nose and Throat Clinic**, you are required to sign a financial responsibility and authorization for treatment form that will be a permanent part of your file.

Forms of Payment: We accept cash, checks, Visa, MasterCard and Discover. WE DO NOT PARTICIPATE WITH CARE CREDIT.
A returned check fee of $35.00 per check returned from your bank for non-payment or insufficient funds is assessed to the patient's account.

Copayments: Your insurance REQUIRES that we collect your designated co-pay **at the time of service**. Please be prepared to pay the co-pay at each visit.

Outstanding Balances: All outstanding balances are the responsibility of the patient (after we have received payment from your insurance company). If you are unable to pay your balance in full, please contact our billing office (308-384-5700)to arrange a payment plan. Our office does not assign interest or late fees to accounts and we expect accounts to be paid in full within 1 year.
Chronic non-payment of your outstanding balances can result in your account being turned over to Credit Management and possible termination of care from our office.

Estimated Surgical Deposits: Should you require a surgery, you are responsible for all fees incurred. These fees can include co-payments, co-insurance, deductibles and any out of pocket expenses for our surgeon's fee, which your insurance company makes you responsible for. You may be required to make a partial or full deposit for the physician fee **PRIOR TO YOUR SURGERY.** Our surgery coordinator will contact you with information pertaining to the amount you will be responsible for. Please be ware that our surgeons (Thomas S. Nabity, M.D. and Kimberly L. Joynt, D.O.)fees are separate from the hospital or surgery center, anesthesiologist and pathology services.
FAILURE TO PAY THESE FEES CAN RESULT IN RESCHEDULING OR CANCELLATION OF YOUR SURGERY.

Insurance: Our office accepts most insurances and we will submit a claim to your insurance company on your behalf. Some services may not be covered and you will be responsible for 100% of those charges. If you decide to see one of our physicians that do not participate with your insurance plan, you will be responsible for all fees and charges. **It is the patient's responsibility to check if our physicians are in network with their insurance company.**

Referrals: If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment and have those papers with you at the time of your appointment.

Workers Compensation: Patients will be financially responsible for services related to accident/workers comp which are denied. Please have injury/accident information available at your appointment, such as Date of Injury, claim number, Insurance Company address, phone number and contact person.

____

Patient Signature/Responsible Party   Date

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HEAD NECK SURGERY
FACIAL PLASTIC SURGERY

ACKNOWLEDGEMENT OF RECEIPT

OF

PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

OFFICE USE ONLY

A good faith effort was made to obtain individual patient acknowledgment of receipt of the notice of policy practices and patients privacy rights, but was unable to do so for the reason documented below:

Date: __________ Initials: ________ Reason ______________________________

____