

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Name (First, Middle Initial, Last) _____ Appt. Date _____

Male _____ Female _____ Date of Birth _____ Ht. _____ Wt. _____

Pharmacy Preference (Include Location) _____

Primary Care Physician _____ Name of Physician who sent you here (if applicable) _____

Chief Complaint: _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications): No ___ Yes ___
(If yes, please list below and be sure to include dosage information)

Name of Medication	Dosage	How often taken

Are you ALLERGIC to ANY medications: No _____ Yes _____ (If yes, please list below)

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATION

Have you had problems with anesthesia (being numbed or put to sleep)? No _____ Yes _____

Please list any surgical implants: _____

Have you had any ear nose or throat surgery? No _____ Yes _____ Please list Type and Date:

Have you had any other surgeries? No _____ Yes _____ Please list Type and Date:

Have you ever been hospitalized for non-surgical reasons? No _____ Yes _____ If yes, please explain:

DAVID M. HARTMAN, M.D.

PATIENT INFORMATION

Name _____
First Middle Initial Last

Mailing Address _____
Street City State Zip Code

Phone (_____) _____ Marital Status M S W D

Alternate Phone # and/or Cell Phone (_____) _____ SSN _____

Sex M F Date of Birth ____/____/____ Email Address: _____
Month Day Year

Name of Physician who sent you here (if applicable) _____ Primary Care Physician _____

Employer _____ Work Phone (_____) _____

WE REQUIRE TWO ADDITIONAL WORKING CONTACT NUMBERS:

Emergency Contact Name _____ Phone (_____) _____

Nearest relative or friend not living with you _____ Phone (_____) _____

INSURANCE INFORMATION

(Complete if patient is insured through spouse or family member **OR** if patient is younger than 18 years old.)

Name _____
First Middle Initial Last

Address _____
Street City State Zip Code

Phone (_____) _____ Date of Birth ____/____/____
Month Day Year

SSN _____ Relationship to Patient _____

HOW DID YOU HEAR ABOUT US? PLEASE CHECK ALL THAT APPLY:

- Physician Friend/Family Member Previous Patient Newspaper Radio commercial
 Yellow Pages Internet Other (please specify): _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Whenever you visit a hospital, physician, or healthcare provider, you are establishing a healthcare record with that provider. Your healthcare record contains notes about your visit, including such things as your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Your healthcare or medical record serves many purposes.

- It may be used to plan your care and treatment.
- It may be used to obtain payment for a third-party, such as an insurance company or Medicare or Medicaid.
- It is a means of communication among the many health professionals who contribute to your care.
- It is a legal document describing the care you received.
- It is a means by which you or a third-party payer can verify that services billed were actually provided.
- It may be used as a tool in educating health professionals or a source of data for medical research.
- It may be a source of information for public health officials.
- It may be a source of data for facility planning and marketing.
- It may be a tool with which we can assess and continually work to improve the care we render and the outcomes we receive.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. It also helps you to understand who may access your health information and under what conditions, and it helps you to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

The physical record of your health is the property of ENT Allergy & Sinus Center, Inc. However, the underlying information belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of your information, however we do not have to comply with your request.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record, except in limited circumstances (you will be charged a reasonable fee for copying).
- Request amendment to your healthcare record.
- Obtain an annual accounting of disclosures of your health information (you will be charged for additional accountings).
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

We do not have to honor your request for restrictions on activities that are otherwise allowable under law.

IF WE DENY YOUR REQUEST, YOU WILL RECEIVE NOTIFICATION OF OUR DENIAL ALONG WITH A WRITTEN BASIS FOR OUR DENIAL.

ANY REQUEST FOR RESTRICTIONS ON USE OR DISCLOSURE MUST BE MADE IN WRITING. WE WILL NOTIFY YOU WITHIN 30 DAYS OF OUR DECISION. WE MAY REQUEST AN ADDITIONAL 30 DAYS TO CONSIDER YOUR REQUEST.

Our Responsibilities:

We are required to:

- Maintain the privacy of your health information.
- Provide you with a Notice of Privacy Practices that describes our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of ENT Allergy & Sinus Center, Inc. Notice of Privacy Practices.
- Notify you if we will not agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices at any time and to make any new provisions effective for all the protected health information we maintain. Prior to making any significant changes in our privacy practices, we will change our Notice of Privacy Practices and post the Notice in the waiting room and in the examination rooms. You will be provided a copy of our new Notice of Privacy Practices if any of our information practices changes.

The office of ENT Allergy & Sinus Center, Inc. will not use or disclose your health information without your authorization, except as described in this notice.

As a condition of treatment (except for emergency treatment) you are required to sign a consent for use and disclosure of Protected Health Information for purposes of payment, treatment, and healthcare operations. We use information about you for treatment, to obtain payment, and to evaluate the quality of care you receive. In certain instances we may use or disclose your information that is not for payment, treatment, or healthcare operations, when required or authorized by law.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with the office of ENT Allergy & Sinus Center, Inc. you may either send a written complaint to 335 Oxford Street, Suite A, Dover, Ohio 44622 or you may call the office of ENT Allergy & Sinus Center, Inc. at 330.602.8833 during our normal business hours. You may also file a complaint with the Secretary of U.S. Department of Health and Human Services in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.