MID-SOUTH EAR, NOSE, AND THROAT, P.C.
PATIENT REGISTRATION

TODAY'S DATE_____ ACCOUNT # _____

WHO IS YOUR APPOINTMENT WITH:
(Circle One)

	Mark A. Milburn, M.D.	Marsha Dean, APN
	John S. Touliatos, M.D.	Lauren Bruff, APN
Thane E. Duncan, PhD., M.D.	Bruce L. Fetterman, M.D.	Amanda Person, APN
Dean A. Klug, M.D.	Anne Moffatt, APN	Gina Lum, APN
Sri I. Naidu, M.D.	Michelle Pattat, APN	Kevin Reed, APN

PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ M.I._____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE ( )_____ WORK PHONE ( )_____ CELL PHONE_____

DATE OF BIRTH_____ **AGE**_____ SS # _____

MARITAL STATUS: SINGLE MARRIED OTHER SEX: F M

EMPLOYER_____ EMAIL_____

PRIMARY CARE PHYSICIAN NAME _____ PHONE ( )_____

EMERGENCY CONTACT INFORMATION

NAME_____ PHONE NO.( )_____ RELATION_____
(RELATIVE/FRIEND NOT LIVING IN SAME HOUSEHOLD)

REFERRING INFORMATION

HOW DID YOU HEAR ABOUT US?
(Circle One)

PHYSICIAN	YELLOW PAGES	FRIEND/RELATIVE
INSURANCE DIRECTORY	INTERNET	WALK-IN

FULL NAME OF PERSON WHO REFERRED YOU _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A CHILD

MOTHER'S INFORMATION

MOTHER'S NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE ( )_____ DATE OF BIRTH_____ S.S. NO._____

EMPLOYER_____ WORK PHONE ( )_____ CELL PHONE_____

FATHER'S INFORMATION

FATHER'S NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE ( )_____ DATE OF BIRTH_____ S.S. NO._____

EMPLOYER_____ WORK PHONE ( )_____ CELL PHONE_____

INSURANCE INFORMATION

Your insurance company requires us to keep your current insurance information and a signed authorization of benefits on file.

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
NAME OF INSURANCE CARRIER	NAME OF INSURANCE CARRIER
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
POLICY HOLDER'S NAME	POLICY HOLDER'S NAME
POLICY HOLDER'S ADDRESS (CITY, STATE, ZIP)	POLICY HOLDER'S ADDRESS (CITY, STATE, ZIP)
POLICY HOLDER'S DATE OF BIRTH	POLICY HOLDER'S DATE OF BIRTH
POLICY HOLDER'S EMPLOYER	POLICY HOLDER'S EMPLOYER
POLICY HOLDER'S ID #	POLICY HOLDER'S ID #
GROUP # / NAME	GROUP # / NAME

Preferred Pharmacy Name: _____ Phone: _____

Name of lab covered by your insurance_____

Name of outpatient/hospital facility you prefer to schedule tests/surgery_____

Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

_____
_____

Please print the telephone number where you want to receive calls about your scheduling, test results, and other health care information if other than your home phone number: _____

I am fully aware that a cell phone is not a secure and private line.

Can we leave a general message requesting a return call to our office on your telephone answering machine or voicemail? **Work** _____YES _____NO **Home** _____YES _____NO

I certify the information I provided on this form is correct to the best of my knowledge.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

MID-SOUTH EAR, NOSE, AND THROAT, P.C.
7600 Wolf River Blvd, Germantown, TN 38138
1458 W. Poplar Ave., Suite 204 Collierville, TN 38017
7378 Yale Road, Bartlett, TN 38133
(901) 755-5300

Authorization For Release Of Information

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer. The Notice is also posted at Mid-South Ear, Nose and Throat, P.C.'s offices.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED** OR **DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED *(such as enrollment in research study or examining you to create a report for your attorney)*.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM.**

THIS AUTHORIZATION IS VOLUNTARY

I, _____, Date of Birth _____ do hereby authorize Mid-South Ear, Nose, and Throat, P.C. to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse the released information may no longer be protected by federal privacy regulations.

I authorize release of information from my medical record (as outlined below and initialed):

_____ Complete medical record that may contain treatment notes regarding radiology, pathology ***(including HIV test results and genetic testing information)***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

OR

_____ For information collected/services described below and provided during the time period of _____.

Description of records to be released:_____

_____

Release my medical records to the following: _____

For the purpose(s) of: _____

Once Mid-South Ear, Nose, and Throat P.C. gives out the information that I want released, I know that the Mid-South Ear, Nose and Throat P.C. has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal and state privacy laws may no longer protect the information.

I understand that I may withdraw my authorization in writing to the Privacy Officer at any time except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***one (1) year from this date*.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative_____
Description of the Representative's authority to act for the patient_____
_____

This form does not have to be completed to release information for treatment payment or healthcare operations except when the information to be released contains confidential details as listed above, privileged categories or certain research information.

PATIENT HEALTH HISTORY

DATE_____

In order for us to obtain a complete medical history, it is important for you 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 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.

Patient's Last Name_____**First**_____**MI**_____

Sex _____ **Male** _____ **Female** **Date of Birth:**_____ **Height**_____ **Weight** _____

Name of Primary Care Physician:_____

Pharmacy Preference (include location):_____

REASON FOR TODAY'S VISIT:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? _____**Yes** _____**No. If yes, please list below:**

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? _____Yes _____No
If yes, please list type of problems:_____

_____

List any surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? _____Yes _____No
If yes, list reasons for hospitalizations:_____

CURRENT OR MOST RECENT OCCUPATION:_____

PAYMENT AGREEMENT

PATIENT NAME _____ ACCOUNT # _____

By signing the space below as patient, guardian or guarantor, or as the patient's guardian, spouse, or guarantor's spouse, I hereby agree that all charges connected with services performed by Mid-South Ear, Nose, and Throat, P.C. not covered by any insurance program, sponsorship, or other third party coverage I may have are due and payable at the time of discharge or discontinuation of treatment.

I hereby acknowledge that Mid-South Ear, Nose, and Throat, P.C. will bill my insurance or third party carrier. I understand that I shall be responsible for all of my charges except those paid under medical insurance. I will be responsible for non-covered services, the deductible, and co-insurance amounts. Deductibles and co-insurance payments are due prior to the surgery date. Post-op visits after endoscopic sinus surgery that include nasal endoscopies are billable charges and will be filed with your insurance. Remaining balances are due upon receipt of an itemized bill. I authorize Mid-South Ear, Nose, and Throat, P.C. to release medical information necessary to process insurance claims. I further authorize payment of medical benefits directly to the physician or supplier of services rendered.

I agree that if I am more than thirty (30) days delinquent in the payment of my bill connected with these charges my account will be referred for collection. I further agree to pay attorney's fees, court cost, and/or collection fees associated with the collection process.

_____ _____

Patient/Guardian/Guarantor Date

FOR MEDICARE PATIENTS ONLY

ONE-TIME PAYMENT AUTHORIZATION & ASSIGNMENT

Medicare Policy #: _____

Medigap Insurance Company: _____ Policy #: _____

I request that payment of authorized Medicare benefits and authorized Medigap benefits be made on my behalf to Mid-South Ear, Nose, and Throat, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or any Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Guardian Date