Low Country ENT

EAR, NOSE & THROAT • HEAD & NECK SURGERY
HEARING AIDS • BALANCE TESTING

Patient Information						
Last Name	First Name				Middle Initial	
Street Address					Apt#	
City		State			Zip Code	
Social Security #	Home Phone			Cell Phone		
Email	D.O.B	Sex(M/F)		Occupation		
Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Employer/School Name					
Street Address				City		
State	Zip Code			Business Phone		

Spouse Information					
Spouse Name			Spouse's Employer		
Spouse Social Security #	Spouse's Birthday	Employer's Address	City	State	Zip

Subscriber/Parent Information if Still Under Parental Care							
Father's Name				Mother's Name			
Address	City	State	Zip	Address	City	State	Zip
Birth date	Soc Security #			Birth date	Soc Security #		
Home Phone	Business Phone			Home Phone	Business Phone		
Employer				Employer			
Employer's Address	City	State	Zip	Employer's Address	City	State	Zip

Insurance Information	
Primary Ins. Company	Policy #
Secondary Ins. Company	Policy #

2850 Tricom St, North Charleston, SC 29406 • 1470 Tobias Gadson Blvd #204, Charleston, SC 29407
Phone: (843) 863-1188 • Fax: (843) 863-8286
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Patient Name: _____

Referring Physician: _____ Family Physician: _____

Pharmacy Name and Address: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following conditions? Please check:

Lungs:
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
- ☐ Bronchitis/Pneumonia

Cardiovascular:
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart valve disease
- ☐ Atrial fibrillation
- ☐ Heart murmur

Hematologic/metabolic:
- ☐ Anemia
- ☐ Bleeding disorder

Autoimmune disease:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hepatitis

Gastrointestinal:
- ☐ Gastroesophageal reflux (GERD)
- ☐ Ulcers
- ☐ Colitis/diverticulitis

Genito-urinary:
- ☐ Kidney stones
- ☐ Urinary tract infections (UTIs)

Musculoskeletal/Neurological:
- ☐ Seizures
- ☐ Headache/migraine
- ☐ Stroke

Sleep:
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ On CPAP

Other:
- ☐ High Cholesterol
- ☐ HIV
- ☐ Glaucoma
- ☐ Cancer: _____

OTHER MEDICAL CONDITIONS YOU MAY HAVE:

_____

PREVIOUS SURGERY

Have you had any surgeries? (include childhood surgery) NO YES (please list below)

Surgery:	Date:

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MEDICATIONS

Are you taking any prescribed or over the counter medicines? NO YES (please list below)

Medication:	Dosage:	Reason for taking:

ALLERGIES

Are you ALLERGIC to any medications? NO YES (please list below)

Medication:	Type of Reaction

FAMILY HISTORY

Is there a family history (immediate family only) of medical problems? NO YES

- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Anesthesia complications
- ☐ Hearing loss
- ☐ Cancer
- ☐ Bleeding problems
- ☐ Other:_____

SOCIAL HISTORY

Do you drink alcohol? NO YES If YES, _____drinks per week
Do you smoke cigarettes? NO YES If YES, how much:_____
If you have QUIT smoking, when did you quit and how long did you smoke_____
Do you do any ILLICIT DRUGS? NO YES If YES, what drug and how often_____
Do you drink caffeine? NO YES If YES_____ drinks per day
Have you had or been exposed to HIV (AIDS)? NO YES
Are you pregnant? NO YES

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REVIEW OF SYSTEMS

Please CHECK only those symptoms you have developed:

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue
- ☐ Headache
- ☐ Anxiety

Eye:
- ☐ Blurred Vision
- ☐ Double Vision

Ear, Nose, Throat:
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Post nasal drip
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Hay fever

Respiratory:
- ☐ Persistent cough
- ☐ Hoarseness
- ☐ Oxygen dependence
- ☐ Productive Cough
- ☐ Wheeze

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations

Gastrointestinal:
- ☐ Acid reflux
- ☐ Difficulty swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genito-urinary:
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control

MEN Only:
- ☐ Breast lump
- ☐ Lump in testicles
- ☐ Erection difficulty

WOMEN Only:
- ☐ Abnormal Pap smear
- ☐ Breast lump
- ☐ Hot flashes

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Neck stiffness
- ☐ Muscle weakness

Skin:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Neurological:
- ☐ Fainting
- ☐ Seizure
- ☐ Balance problems/dizziness
- ☐ Tremors
- ☐ Memory problems

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Russell Kitch, MD • Jenn Grady, MD • Jeffery Neal, MD • Julie Malka, AuD
North Charleston • West Ashley

Medical Information Disclosure

I _____ give Low Country ENT my permission to disclose any medical information about myself or my child to the people listed below. If the patient is a minor (under the age of 18) please list anyone who can bring the child to the appointment.

Spouse: _____

Grandparents: _____

Parent/Guardian: _____

Please list anyone else who we may disclose your medical information**:**

_____

_____

_____

Signature of patient Date

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FINANCIAL POLICY

YOUR INSURANCE:

We accept assignment of benefits from many insurance companies. For those insurance companies we have a contract with, we will bill those plans and only require you to pay the co-payment at the time of service. If you have an insurance that requires an authorization, it is ultimately your responsibility to obtain this from your Primary Care Physician. All charges that remain after 30 days will be charged a minimum be of $10.00 per month unless payment arrangements have been made. Any account that goes to collections will be charged a collection fee.

CO-PAYS:

All co-pays are due at CHECK IN. If you do NOT have insurance or your co-pay is a percentage (e.g. 20%, 15%), those co-pays will be figured at check-out. However, if you are a NEW patient and you have no insurance you will be expected to bring $225.00 with you at your first visit. That fee will be collected at CHECK-IN. That amount sometimes does not cover the visit cost in full. The full cost depends on any additional tests, procedures or services that need to be done during your visit to help you get well.

MINOR PATIENTS:

Any patient under the age of 18 will not be seen without a parent or guardian present.

NO-SHOW FOR AN APPOINTMENT:

There will be a $25.00 charge for any appointments that are not canceled within at least a 12 hour notice.

RETURN CHECK POLICY:

There will be a $35.00 fee for all return checks.

I have read and understand the financial policy above of the practice. I agree to be bound by its terms. I understand and agree that such terms may be amended from time to time by the practice.

Signature Date