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
Lowcountryent.com

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Patient Name: _____

Referring Physician: _____ Family Physician: _____

Pharmacy Name and Address: _____

MEDICAL HISTORY/BIRTH HISTORY:

Method of delivery: ☐ normal vaginal ☐ cesarean section

Was child born premature? ☐NO ☐YES If YES, list gestational age_____weeks

Was child in the NICU? ☐NO ☐YES If YES, was child intubated? ☐NO ☐YES

Did child pass newborn hearing screen? ☐YES ☐NO ☐UNSURE

Was child breastfed? ☐ YES ☐ NO

Please indicate any therapy child is receiving: ☐ PT ☐ OT ☐Speech ☐Other:_____

Are your child's immunizations up to date? ☐ YES ☐ NO

Does your child have or ever had any of the following conditions? Please check:

- ☐ Infection/complications during pregnancy:_____
- ☐ Ear infections in past 12 months:_____
- ☐ Strep throat/sore throat episodes in past 12 months:_____
- ☐ Bronchitis/Pneumonia
- ☐ Tuberculosis
- ☐ Cystic fibrosis
- ☐ Heart problems:_____
- ☐ Stomach or intestinal problems:_____
- ☐ Bladder/Urinary tract infections (UTIs)
- ☐ Seizures
- ☐ Headache/migraine
- ☐ ADHD/ADD
- ☐ Behavior/developmental disorders:_____
- ☐ Easy bruising/Bleeding disorder:_____
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Cancer/leukemia

OTHER MEDICAL CONDITIONS YOUR CHILD MAY HAVE:

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PREVIOUS SURGERY

Has your child had any surgeries? NO YES (please list below)

Surgery:	Date:

MEDICATIONS

Is your child taking any prescribed or over the counter medicines? NO YES (please list below)

Medication:	Dosage:	Reason for taking:

ALLERGIES

Is your child 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
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Problems with anesthesia
- ☐ Bleeding problems
- ☐ High blood pressure
- ☐ Hearing loss
- ☐ Other:_____

SOCIAL HISTORY

Does your child attend day care? NO YES
Are there pets in the house? NO YES If YES, number/types:_____
Is there smoke exposure? NO YES If YES, describe exposure:_____
Who does the child live with? (Include siblings):_____
School grade?_____
List any special schools or classes:_____

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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

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

Eye:
- ☐ Blurred Vision
- ☐ Double Vision

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