PATIENT INFORMATION **1325 Dry Creek Dr., Longmont, CO 80503**

Patient Last Name _____ First _____ MI _____

Patient Address _____City _____State _____ Zip _____

Hm Ph _____ Work _____ Cell _____

Date of Birth _____/_____/_____ Age_____ Preferred # to call? Hm _____ Cell _____ Wk _____

Marital Status: S M D W Male_____ Female _____

Email address for Web Portal:_____

Emergency Contact _____Relationship _____M/F_____Phone_____

Address (if different than patient)_____

Please check below: (Insurance Requirement)

White (Caucasian) ___ Black/African American ___ Hispanic/Latino ___ Native Hawaiian ___ Other Pacific Islander _____

Asian ___ American Indian/Alaska Native ___ More than one race ___ Other _____ I refuse to report _____

Who is Referring/Primary Care Physician: (Please list name of Dr., PCP, PA, or NP)

_____

INSURANCE INFORMATION:

Your insurance plan may require you to have a referral. Contact the referring provider's office and have them fax one to us if one is needed as our office does not check that for you. It is your responsibility to see that we get it prior to your appointment from your referring/Primary Care Physician or you may be responsible for the cost of your visit.

Primary Ins. Carrier_____ Policy # _____ Group #_____

Name of Primary/Guarantor Policy Holder: _____

His / Her Date of Birth: _____ Male_____ Female_____

Secondary Ins. Carrier _____ Policy # _____ Group # _____

Name of Secondary/Guarantor Policy Holder: _____

His / Her Date of Birth: _____ Male_____ Female_____

I authorize payment of insurance benefits directly to Front Range Otolaryngology & Facial Plastic Surgery, PC. I understand that I am financially responsible for all co-insurance and/or deductibles whether or not paid by insurance. Each visit I will be responsible for the full amount on the 1st mailed billing statement. We offer a 3-month payment plan that needs to be set up upon the 1st mailed billing statement. I understand there is a $17.00 admin fee after 3 months if no payment is made, and statement goes to collections. In addition, there is a $50.00 no show fee if a 24-hour notice is not provided.

Patient's Signature_____ Guardian/Insured's Signature _____

1. Please specifically give the reason for your visit: _____

2. Please list any drug-related allergies or intolerances: _____

3. Have you ever seen an allergist? _____ If yes, Name: _____

4. Do you have (or have you had) any of the following ailments? Please check box if yes.

Past		Current	Past		Current
☐	Diabetes	☐	☐	Nose Bleeds	☐
☐	+HIV/AIDS	☐	☐	Anemia	☐
☐	Hepatitis	☐	☐	Difficulty breathing through nose	☐

PLEASE ANSWER ALL QUESTIONS COMPLETELY

5. Do you or have you ever smoked? Yes ___ No ___. How many packs per day do you smoke? ____ How many packs per day when you did smoke? ____ For how many years? _____. What year did you quit smoking? _____. Do you currently use chewing tobacco?Yes __ No___ Cigars? Yes ___ No___

6. Do you drink alcohol? Yes ____ No ____ How much do you drink? ____ Per day/week/month. Has alcohol ever been a problem? Yes___ No___ Have you ever used illicit drugs? Yes ____ No _____

7. Please list any current medical conditions: (examples: high cholesterol, thyroid disease, heart conditions, COPD etc.)

_____

_____

8. List any previous surgeries or major illnesses you have had along with approximate dates: _____

_____

_____

9 List all medications you are currently taking (include over-the-counter medicines, aspirin or aspirin containing medicines, birth control pills, vitamins, supplements, herbs) along with dosage: _____

_____

_____

(Check box if YES)

10. Have you had any exposure to HIV through prior sexual history, surgery, transfusion or IV drug use? ☐
Have you had a reaction to anesthetics? ☐
Have you ever had a blood transfusion? ☐
Have you ever been under the care of a psychiatrist or had a nervous breakdown? ☐
Do you have a history of bad scarring? ☐
If yes where? _____

11. Family History (Please check box if YES)

Alcoholism	☐	Family Estrangements	☐
Allergies	☐	Heart Attacks	☐
Bleeding Tendencies	☐	High Blood Pressure	☐
Cancer	☐	Nervous Breakdown	☐
Congenital Defects	☐	Stomach Problems	☐
Diabetes	☐	Strokes	☐
Epilepsy	☐	Suicide	☐

12. HEIGHT: _____ WEIGHT: _____

13. List any other important information: _____

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians.

(Signature) _____ (Date) _____/_____/_____

Patient Health Questionnaire

Name_____ Rev _____ Date _____

Family History (such as diabetes, cancer, arthritis, heart disease, blood disease):_____

_____

Review of Symptoms: Please circle any of the following symptoms, complaints, or problems you have had recently or have had problems with in the past. **IF NONE PLEASE CIRCLE NONE**

General Symptoms:
Fever
Weight loss > 10 lbs
Weight gain > 10 lbs
Fatigue
Headaches
Head injury
Other_____
NONE

Eyes:
Double vision
Blurring
Trauma
Glasses/Contacts
Other_____
NONE

Ears, Nose, Throat & Mouth:
Decreased hearing
Sinusitis
Hoarseness
Vertigo
Tinnitus
Nasal Allergies
Other_____
NONE

Cardiovascular:
Chest pain
Palpitations
Heart attack
Irregular beats
Other_____
NONE

Respiratory:
Shortness of breath
Asthma
Cough
Spitting blood
Sleep Apnea
Other_____
NONE

Gastrointestinal:
Diarrhea
Constipation
Abdominal pain
Ulcers
Vomiting
Other_____
NONE

Musculoskeletal:
Fractures
Sprains
Joint pain
Arthritis
Stiffness
Atrophy
Other_____
NONE

Skin:
Rashes
New lesions
History of scarring
Masses
Other_____
NONE

Neurological:
Speech & swallowing problems
Changes in sensations
Seizures
Weakness
Balance problems
Decreased memory
Coordination problems
Dizziness
Other_____
NONE

Endocrine:
Appetite change
Excessive thirst
Hyperactivity
Thyroid disease
Diabetes
Other_____
NONE

Psychological:
Depression
Mood Changes
Hallucinations
Changes in sleep pattern
Anxiety
Other_____
NONE

Allergic/Immunologic:
Skin Inflammation
Eczema
Hives
Other_____
NONE

Hematologic/Lymphatic:
Bleeding tendencies
Lymph node pain/enlargement
Anemia
Exposure to HIV
History of blood transfusion
Other_____
NONE

Front Range Otolaryngology & Facial Plastic Surgery, P.C.

_____ _____

Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Front Range Otolaryngology and Facial Plastic Surgery's Notice of Privacy Practices. (Please read below)

_____ _____

Signature of Patient or Patient Representative **Date Signed**

Documentation of Good Faith Efforts
To Obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

____/___/____

The patient presented to the office on (insert date) and was provided with a copy of FROFPS's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  _____
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- ☐ Other reason _____

_____ _____

Employee Signature Date

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

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

Front Range Otolaryngology and Facial Plastic Surgery's LEGAL DUTY

FROFPS is required by law to protect the privacy of your personal health information, provide notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

FROFPS uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example; FROFPS may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

FROFPS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, FROFPS's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENTS'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. FROFPS will consider all such request on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that FROFPS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at 720-494-9111. You may also send a written complaint to the US Department of Health and Human Services. Complete Notice of Privacy Practices available upon request.