EAR, NOSE & THROAT
Specialists of Nashville

Mark A. Williams, M.D., Ph.D.
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Pre-Registration Instructions

Thank you for visiting our website and deciding to entrust us with your otolaryngic care. The following pages contain forms that, if you would completely fill them out before your appointment, will expedite your visit. Before completing the information, please read the following notes carefully.

1. Please completely fill out the attached forms with all of the information requested.

2. The "Bubblesheets" require that the circles be completely filled in to register with our scanner. You may use an ink pen or a pencil to complete this.

3. Please include the name, dose and frequency of each medication you take. Remember to list any allergies.

4. On the date of your appointment, please remember to bring a photo ID and your insurance card, in addition to these completed forms.

5. If you have had any imaging studies (i.e. CT Scan or MRI of the head/neck/sinuses, etc.) please obtain a CD of the images and bring it with you to your appointment. The physician (or nurse practitioner/physician assistant) will need to see the images and not just the radiologist's written report to determine the most appropriate treatment for you.

At Ear, Nose & Throat Specialists of Nashville, we strive to provide you with unparalleled and compassionate otolaryngic care in an expedient fashion. We desire to accommodate your schedule. To help with this goal, we employ highly skilled physician extenders (i.e., nurse practitioners and/or physician assistants) who are fully capable of treating most diseases of the ear, nose and throat. They are available Monday-Friday from 9:00 am – 5:00 pm, while the physician's schedule is more limited due planned and emergency surgeries. Your willingness to be seen by one of the physician extenders will help us secure an appointment for you sooner. If you must be seen by a physician only, please notify our staff when they contact you for an appointment. You will be given a "Physician-Only" appointment.

Again, thank you for entrusting us with your care and we look forward to serving you!

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Demographics

Patient's Name: _____ *Age:* ____ *Date of Birth:* _____ *SS#:* _____

Address: _____ *City:* _____ *State:* ____ *Zip:* _____ *Sex: M* ☐ *F* ☐

Home Phone # _____ *Cell Phone #*_____ *Marital Status: Married* ☐ *Single*☐ *Divorced*☐

Employer: _____ *Work Phone #:*_____ *Full Time* ☐ *Part Time* ☐

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Spouse Name: _____ *Date of Birth:* _____ *Spouse Contact #* _____

Emergency Contact (other than Spouse): _____ *Phone #:* _____

Relationship to Patient: _____

Email address: _____ *Can we send appointment reminders by email:* ☐ *Yes* ☐ *No*

Insurance/Referral

Do you have insurance through your employer? Yes ☐ *No*☐
Is this a work related injury: Yes ☐ *No* ☐ *Date injury occurred:* _____

PRIMARY INSURANCE
Insured's Name: _____ *Name of Insurance:* _____
Relationship to you: Self ☐ *Spouse* ☐ *Parent* ☐ *Other* ☐
Insured's Date of Birth: _____ *Insured's SS#*_____ *Insured's ID#*_____
SECONDARY INSURANCE
Insured's Name: _____ *Name of Insurance:* _____
*Insured's ID#*_____

Referral Physician _____ *Primary Physician (if different)* _____

*Pharmacy Name:*_____ *Street:*_____ *Phone:* _____

How did you hear about us?

☐ *Our Website*	☐ *Insurance Provider Directory*	☐ *Other* _____
☐ *Yellow Pages*	☐ *Yellow Book*	☐ *Existing Patient* _____
☐ *Internet search*	☐ *Physician* _____	☐ *Friend* _____

Authorization/ HIPPA

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting healthcare personnel; any health, accident, auto, or workman compensation insurance carrier, any agent, attorney, or other representative supporting to act on my behalf; and any facility at which I am treated, examined or evaluated. I also authorize my Insurance Company to pay Ear, Nose & Throat Specialists of Nashville, PLC any benefits due on this claim, I understand that lam financially responsible for any amount not covered by my Insurance. Should I be covered by Medicare, I request that payment of authorized Medicare benefits he made to Ear, Nose & Throat Specialists of Nashville. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits.

I have received/viewed the HIPAA Notice of Privacy Practices: _____ *Date:* _____
Signature of Patient or Authorized Representative: _____ *Date:* _____

Ear, Nose and Throat Specialist of Nashville | 393 Wallace Road Building A Ste 202 | Nashville, TN 37211

Phone: 615-832-2200 | Fax: 615-832-2020

Mark A. Williams, M.D. PH.D | Jana Wheeler, PNP, BC

To: _____

I hereby authorize you to release medical records for:

_____

Patient's Name

_____

DOB

_____

Social Security Number

The information that I am requesting is: All Record Labs

Other: _____

If the Medical Records are more than 15 pages please mail all records to the above address listed.

Date: _____

Signature: _____

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Ear, Nose & Throat Specialist of Nashville

Phone: 615-832-2200 Fax: 615-832-2020

Medication History:

Are you taking any diet medications, herbal preparations, vitamins, or any other over the counter medications (i.e., Ginseng, Tylenol, Advil, Aspirin, Visine eye drops, Multivitamins, etc.)?

List any medications you take at home including oral meds, insulin, inhalers

Medication	Dose	Frequency	Last Dose

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____

EAR, NOSE & THROAT
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Patient Payment Agreement

We attempt to obtain benefits from your insurance company and give you the best information possible. However; **ENTSON will not be responsible for any discrepancies between quoted benefits and actual benefits paid by your insurance**. We do encourage you to call your insurance company and verify medical in network and out of network office visit for specialists. It is your responsibility to know and understand your plan limitations, maximum benefits available, deductibles, copayments and coinsurance amounts. **You will be responsible for payment of amounts not covered by your insurance.**

Co-Payment:
For patients with a fixed co-payment amount for each visit, please be prepared to pay your co-payment at each appointment. Be advised that your co-payment for a specialist visit is often different from that for a primary care visit.

Co-Insurance:
If your insurance requires you to pay a co-insurance, an, **estimated** co-insurance payment will be collected at each visit. For example, if your co-insurance is 20% and the estimated charges for the day is $200 you will be expected to pay $40 ($200 x 0.20) at the end of your visit. Final calculation of your co-insurance liability will be done after all payments have been received from your insurance carrier. At that time, you will receive a statement for any remaining balance due, or you will be promptly refunded for any overpayment, whichever may apply.

Deductibles:
Deductibles owed are handled in the same manner. We collect on deductibles at each visit as an **estimated** amount that will be applied toward your deductible until your deductible has been met, because the amount is estimated final calculation of your deductible will be done after all payments have been received from you insurance carrier. This does not represent payment in full for your daily treatment. Once the deductible has been met, if applicable, we will then collect towards your co-insurance in the same manner as stated above.

Self Pay Patients:
For un-insured patients payment is expected in full at time of visit a 20% discount is offered if paid on the date of service. Payment may range from $171-$400 before 20% discount is applied.

We accept checks, Visa, MasterCard, Discover, & Care Credit.
A $20.00 fee will be charged on all returned checks. Statements not paid by due date shown will be assessed a $5.00 rebill fee.

AGREEMENT: I understand and agree that I am responsible for verifying my own insurance benefits. Because my insurance coverage is a contract between myself and my insurance company, I understand that I must direct questions or concerns regarding payment of benefits to my insurance company. I agree to pay all charges for me and my family members shown by statement within 30 days after receipt, unless credit arrangements have been made. Charges are to be paid in full regardless of any arbitrary decision made by my insurance company regarding usual and customary fees. It is agreed that payment will not be delayed or withheld because of any insurance claims pending, and all proceeds of insurance are assigned to this office where applicable (a copy of this assignment is as valid as the original). In the event legal action should become necessary to collect unpaid balances due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Patient or Responsible Party: _____ *Date:* _____

CANCELLATION / NO SHOW POLICY

Your scheduled appointment is a specific time when you are to be seen by a physician. It is imperative that you attend each appointment and be on time. Our goal is to help you get better and the only way that can be accomplished is for you to attend your appointment. If you are unable to keep your appointment, we ask that you call to cancel at least **24 hours** in advance or we reserve the right to charge you a **$25 fee**. In addition, if you fail to keep **three** appointments, you will be dismissed from ENTSON and will be required to return to your referring physician office to obtain a new referral.

Patient or Responsible Party: _____ *Date:* _____

Ear, Nose & Throat of Nashville

Patient Name: _____ DOB:_____Visit Date: _____

"Please mark YES or NO for symptoms you have had in the last two weeks"

General

Weight Loss:	O Yes	O No
Excessive Weight Gain	O Yes	O No
Fever:	O Yes	O No
Chills:	O Yes	O No
General Sick Feeling:	O Yes	O No

Cardiovascular

Chest pain:	O Yes	O No
Racing heart:	O Yes	O No
Irregular Heartbeat:	O Yes	O No
Fainting spells:	O Yes	O No
Shortness of breath with activity:	O Yes	O No
Leg pain w/ walking:	O Yes	O No
Inability to sleep lying flat:	O Yes	O No

Respiratory

Chronic cough:	O Yes	O No
Shortness of Breath:	O Yes	O No
Wheezing:	O Yes	O No
Noisy breathing:	O Yes	O No

Gastrointestinal

Nausea:	O Yes	O No
Vomiting:	O Yes	O No
Difficult/Painful swallowing:	O Yes	O No
Stomach pain:	O Yes	O No
Blood in stools:	O Yes	O No
Constipation:	O Yes	O No
Diarrhea:	O Yes	O No
Change in bowels habits:	O Yes	O No

Genitourinary

Frequent urination:	O Yes	O No
Painful urination:	O Yes	O No
Blood in urine:	O Yes	O No
Sexual dysfunction:	O Yes	O No
Abnormal bleeding:	O Yes	O No

Musculoskeletal

Muscle pain:	O Yes	O No
Joint Pain:	O Yes	O No
Weakness:	O Yes	O No
Cramps:	O Yes	O No

Hematologic

Anemia:	O Yes	O No
Easy Bruising:	O Yes	O No
Previous blood transfusions:	O Yes	O No
Reactions to previous transfusions:	O Yes	O No

Neurologic

Headaches:	O Yes	O No
Seizures:	O Yes	O No
Tingling/Numbness:	O Yes	O No
Strange feelings:	O Yes	O No
Uncoordinated:	O Yes	O No
Weakness:	O Yes	O No

Psychiatric

Changes in mood:	O Yes	O No
Thoughts of suicide:	O Yes	O No
Anxiety:	O Yes	O No
Depression:	O Yes	O No
Hallucinations:	O Yes	O No

Skin

Rashes:	O Yes	O No
New/changing marks on skin:	O Yes	O No
Itching/Dryness:	O Yes	O No
Hair loss:	O Yes	O No
Change in moisture or texture of skin:	O Yes	O No

Endocrine

Heat Intolerance:	O Yes	O No
Cold Intolerance:	O Yes	O No
Racing heart:	O Yes	O No
Weight gain/loss:	O Yes	O No
Excessive hunger:	O Yes	O No
Excessive thirst:	O Yes	O No
Excessive urination:	O Yes	O No

Immune/Allergy

Itchy/Watery eyes:	O Yes	O No
Sneezing:	O Yes	O No
Runny nose:	O Yes	O No
Known allergies:	O Yes	O No
Reactions of food or insect bites:	O Yes	O No
Previous allergy testing:	O Yes	O No

Eyes

Blurred vision:	O Yes	O No
Double vision:	O Yes	O No
Blindness:	O Yes	O No
Seeing spots:	O Yes	O No
Eye pain:	O Yes	O No

ENT

Hearing loss:	O Yes	O No
Ringing/Noise in ears:	O Yes	O No
Dizziness/spinning sensation:	O Yes	O No
Feeling of water in ears:	O Yes	O No
Ear pain:	O Yes	O No
Change in sense of smell:	O Yes	O No
Change in sense of taste:	O Yes	O No
Nasal congestion:	O Yes	O No
Post Nasal drip:	O Yes	O No
Runny nose:	O Yes	O No
Nose bleeds:	O Yes	O No
Sore throat:	O Yes	O No

Surgical History O **NONE** (Please mark NONE if nothing below applies)

- O Colonoscopy
- O EGD(Upper endoscopy)
- O Ulcer Surgery
- O Colon Surgery
- O Gall bladder surgery
- O Appendectomy
- O Hemorrhoidectomy
- O Bypass Surgery
- O Heart Valve Replacement
- O Hysterectomy
- O Breast Cancer Surgery
- O Prostate Surgery
- O Back Surgery
- O Joint Surgery
- O Tonsillectomy/Adenoidectomy
- O Ear Tubes
- O Sinus surgery
- O Ear surgery/Mastoidectomy
- O Tympanoplasty
- O Nose surgery/Septoplasty

Past Medical History O **NONE (Mark only those that apply or NONE)**

O Rheumatic Fever	O High/Bad cholesterol	O Cancer
O Scarlet Fever	O Lung Disease/Asthma	O Heart disease
O Heart Murmur	O Emphysema/COPD	O Thyroid disease
O High blood pressure	O Stroke	O Tuberculosis
O Diabetes	O Bleeding problems	O Other

Family History **Mark only those that apply or NONE**

Mother O NONE O High Blood pressure O Diabetes O High cholesterol
O Heart Attack O Coronary Heart disease O Angina
O Bypass Surgery O Sudden Death O Heart Failure O Stroke O Seizures

Father O NONE O High Blood pressure O Diabetes O High cholesterol
O Heart Attack O Coronary Heart disease O Angina
O Bypass Surgery O Sudden Death O Heart Failure O Stroke O Seizures

Other Relatives O NONE O High Blood pressure O Diabetes O High cholesterol
O Heart Attack O Coronary Heart disease O Angina
O Bypass Surgery O Sudden Death O Heart Failure O Stroke O Seizures

Social History

Marital status: O Married O Single O Divorced O Widowed O Life Partner
Occupation: O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Who Lives with you: O Spouse O Children O Partner O Mother O Father O No one

Exercise: O Never O Daily O 1-2 times per week O 3-4 times per week

Caffeine use: O None O Daily O Occasionally

If yes: O 1 cup/drink a day O 2-3 cups/drinks a day O 4 or more cups/drinks a day

Tobacco use: O Yes O No O Trying to Quit O Previous smoker O Cigarettes O Cigars O Smokeless Tobacco

If yes, Cigarette daily use: O ½ pack O 1 pack O 2 packs O more than 2 packs /day

If yes, number of years: O 0-10 years O 10-20 years O 20-40 years O 40 + years

Alcohol use: O Never O Daily O Social Drinker O Trying to Quit O Recovering Alcoholic

If yes: O Less than 12 drinks a month O 1-12 drinks a month O 4-15 drinks a week O more than 2 drinks a day

Recreation drug use: O No O Yes O Occasionally O Previous user

If yes: O Marijuana O Cocaine O Heroine O Other _____