ROANOKE VALLEY ENT & ALLERGY

Patient Information

Patient Name: _____ _____ _____ Date of Birth: _____
First Middle Last

Gender: Male☐ Female☐ Social Security Number: _____

Mobile Number: _____ Home Number: _____

Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

How did you learn about our office:_____

Emergency Contact:

Name:_____ Relationship to Patient:_____

Phone Number: _____

Responsible Party (if other than patient):

Guarantor's Name:_____ Guarantor's Date of Birth: : _____

Relationship to Patient: _____ Phone Number:_____

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

Guarantor's Employer: _____

Employer's Address: _____

City:_____ State:_____ Zip:_____

Patient Name: _____ **Today's Date:** _____

Do you have a known **drug allergy**? Yes ☐ No ☐
If yes, to what & what were your symptoms?: _____

Do you have a **latex allergy**? Yes ☐ No ☐ Do you have a **shellfish allergy**? Yes ☐ No ☐

Have you been you been **hospitalized for allergies** and/or **asthma**?: Yes ☐ No ☐ If yes, when: _____

Have you been **allergy tested?** Yes ☐ No ☐ If yes, date of test: _____ Where?: _____

Have you had a **CT scan** of your sinuses in the past 12 months?: Yes ☐ No ☐
If yes, when?: _____ Where was it performed?: _____

How many courses of **antibiotics** have you been treated with in the **past 1 year**?: _____

Have you ever had or do you currently suffer from any of the following conditions? (check all that apply)

- ○ Anemia/Blood Disorder
- ○ Asthma
- ○ Arthritis
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Bone Disease/Osteoporosis
- ○ Cancer/Chemotherapy
- ○ Diabetes
- ○ Epilepsy
- ○ Excessive Bleeding
- ○ Heart Disease/Murmur
- ○ HIV/AIDs
- ○ Hepatitis A, B or C
- ○ Immune Disorders
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lung Disease
- ○ Pacemaker
- ○ Radiation Therapy
- ○ Sinus Problems
- ○ Stomach Issues
- ○ Stroke
- ○ Surgery
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Tumor(s)

What symptoms are you experiencing? (check all that apply)

- ○ Nasal Congestion
- ○ Runny Nose
- ○ Fever
- ○ Headache
- ○ Change in smell/taste
- ○ Sneezing
- ○ Cough
- ○ Pressure in ears
- ○ Hoarseness
- ○ Other: _____
- ○ Post nasal drainage
- ○ Sore throat
- ○ Facial pain/pressure
- ○ Snoring

What have you taken OVER THE COUNTER in the past 1 YEAR for your symptoms? (check all that apply)

- ○ Astelin
- ○ Astepro
- ○ Claritin/Loratadine
- ○ Allegra/Fexofenadine
- ○ Nasonex/Mometasone
- ○ Zyrtec/Cetirizine
- ○ Flonase/Fluticasone
- ○ Xyzal/Levocetirizine
- ○ Neti Pot/Saline Rinse
- ○ Saline Nasal Spray
- ○ Ayr
- ○ Tylenol Cold and Sinus
- ○ Afrin Nasal Spray
- ○ Sudafed
- ○ Benadryl
- ○ Zicam Allergy Relief
- ○ Advil Cold and Sinus
- ○ DayQuil/NyQuil

What PRESCRIPTIONS have you taken in the past 1 YEAR for these symptoms? (check all that apply)

- ○ Dymista
- ○ Patanase
- ○ QNasal
- ○ Levaquin
- ○ Amoxicillin
- ○ Medrol Dose Pack
- ○ Cephalexin
- ○ Ceftin
- ○ Cipro
- ○ Zithromax Z-Pack
- ○ Avelox
- ○ Keflex
- ○ Omnicef/Cefdinir
- ○ Augmentin
- ○ Prednisone
- ○ Doxycycline
- ○ Atrovent
- ○ Other: _____

ROANOKE VALLEY ENT & ALLERGY

Patient Acknowledgement of Financial Responsibility

I hereby authorize Roanoke Valley ENT, PC to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Roanoke Valley ENT, PC of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Consent For Use or Disclosure of Patient Information for the Purposes of Treatment, Payment, and Healthcare Operations

I hereby consent to Roanoke Valley ENT, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the practice's health care operations. I also consent to Roanoke Valley ENT, PC using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Release of Information:

I request and authorize Roanoke Valley ENT, P.C. to disclose protected health information to the individual(s) listed below:

Name: _____ Name: _____ Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that Roanoke Valley ENT & Allergy provided me with a copy of a separate document, entitled "Notice of Privacy Practices" which sets forth this group's privacy practices and my rights regarding privacy of my protected health information.

Patient's Name: _____ Today's Date: _____

Guarantor's Name: _____ Relationship to Patient: _____
(if other than the patient)

Patient or Guarantor's Signature: _____

ROANOKE VALLEY ENT & ALLERGY

In-Office Procedure Consent

Please be aware that depending on the nature of your specific medical condition and treatment, your physician may perform certain in-office procedures that are not included in the standard office visit. This is because, as a highly trained specialist, your physician wants to ensure that all appropriate steps are taken to provide you with the absolute best medical care possible. These procedures will be billed separately from your visit charges. Depending on your individual insurance policy and carrier, these procedures may be classified as "surgery" and applied to an in-network deductible. In these cases, the amount allowed for the procedure by your insurance will be your financial responsibility.

Examples of these procedures are:

Nasal Endoscopy: Common reasons for performing this procedure during your office visit include nasal airway obstruction, suspected chronic sinusitis, nasal/facial pain, snoring, and nosebleeds. This exam allows a complete and detailed visualization of all nasal mucosa, nasal turbinates, openings into the sinuses and nasopharynx. It is performed while the patient sits in an upright position and the flexible or rigid endoscope is gently passed through the nasal cavity to the back of the nose.

Flexible Laryngoscopy: Common reasons for performing this procedure during your visit include hoarseness, suspected vocal cord lesions, shortness of breath, difficulty swallowing, thyroid conditions, sleep apnea and history of tobacco use. This exam allows the physician to directly observe the structures of the throat and vocal cords. It is performed while the patient sits in an upright position and the flexible endoscopy is either passed along the floor of the nose into the back of the throat or is done transoral depending on the patients' comfort level.

Flexible Endoscope

Rigid Endoscope

Cerumen Removal: Manual removal of earwax. This is performed by our doctors using suction or specialized instruments to remove ear wax in a safe and effective manner.
Endoscopy Control of Epistaxis (Nosebleed): The physician uses the rigid endoscope to visualize the bleeding site and will then cauterize and/or apply a thin patch to control the bleeding.

Sinus Debridement: Sinus debridement/cleaning is performed at your visit following your sinus procedure. This is done to remove blood, mucus and crusts that build up in the sinuses which could lead to infection and further obstruction. Some patients may require additional debridements depending on the severity of their sinus disease at the time of surgery.

I acknowledge that I have read and understand the above.

Patient's Name: _____ Today's Date: _____

Guarantor's Name: _____ Relationship to Patient: _____
(if other than the patient)

Patient or Guarantor's Signature: _____

SINO-NASAL OUTCOME TEST (SNOT-20)

Name: _____ Date: _____

We would like to know more about your sinusitis and would appreciate your answering the following questions to the best of your ability.

Below you will find a list of symptoms and social/emotional consequences of your sinusitis. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks.

1. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →

	No Problem	Very Mild Problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as severe as it can get	5 Most important items
Need to blow nose	0	1	2	3	4	5	O
Sneezing	0	1	2	3	4	5	O
Runny nose	0	1	2	3	4	5	O
Cough	0	1	2	3	4	5	O
Post-nasal discharge	0	1	2	3	4	5	O
Thick nasal discharge	0	1	2	3	4	5	O
Ear fullness	0	1	2	3	4	5	O
Dizziness	0	1	2	3	4	5	O
Ear Pain	0	1	2	3	4	5	O
Facial pain/pressure	0	1	2	3	4	5	O
Difficulty falling asleep	0	1	2	3	4	5	O
Wake up at night	0	1	2	3	4	5	O
Lack of a good night's sleep	0	1	2	3	4	5	O
Wake up tired	0	1	2	3	4	5	O
Fatigue	0	1	2	3	4	5	O
Reduced productivity	0	1	2	3	4	5	O
Reduced concentration	0	1	2	3	4	5	O
Frustrated/restless/irritable	0	1	2	3	4	5	O
Sad	0	1	2	3	4	5	O
Embarrassed	0	1	2	3	4	5	O

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

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