## Patient Information

Patient Name: ______________ _______________ _______________ Date of Birth: _________________

First Middle Last

Gender: _______________________________ Social Security Number: ____________________

Home Number: (_______)_______-__________ Mobile Number: (_______)_______-__________

Email Address: ___________________________________________________________________________

Mailing Address: __________________________________________________________________________

City:___________________________ State: ________ Zip Code:___________

**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: (_______)_______-__________

**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 **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)
- ☐ Zyrtec (Cetirizine)
- ☐ Xyzal (Levocetirizine)
- ☐ Flonase (Fluticasone)
- ☐ Nasonex (Mometasone)
- ☐ 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:_________________

## 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 as valid as the original.

## Consent for Use of 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, PC 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, upon my request, Roanoke Valley ENT, PC 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.

I certify that I have ready and fully understand the above statements and consent fully and voluntarily to their contents.

Patient's Name: ___________________________________ Today's Date: __________________________

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

Patient or Guarantor's Signature: ___________________________________

## In-Office Procedure Information

Please be aware that, depending on the nature of your specific medical condition and treatment, your provider may perform certain in-office procedures that are not included in the standard office visit. This is because, as a highly trained specialist, your provider 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, or nosebleeds. This exam allows a complete and detailed visualization of all nasal mucosa, nasal turbinates, and openings into the sinuses and nasopharynx. It is performed while the patient sits in an upright position and the endoscope is gently passed through the nasal cavity in 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, sleep apnea, and history of tobacco use. This exam allows the provider 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 endoscope is gently passed along the floor of the nose into the back of the throat.

**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.

**Control of Epistaxis (Nosebleed):** The provider 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 a 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 the procedure.

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 22)

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 effects of sinusitis. There are no wrong answers, and only you can provide us with this information. Please rate the following as they have been **over the past two weeks**.

**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 | ○ |
| **Sneezing** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Runny nose** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Nasal blockage** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Cough** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Decreased sense of smell/taste** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Post-nasal discharge** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Thick nasal discharge** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Ear fullness** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Ear pain** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Dizziness** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Facial pain/pressure** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Difficulty falling asleep** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Wake up at night** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Lack of a good night's sleep** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Wake up tired** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Fatigue** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Reduced productivity** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Reduced concentration** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Frustrated/restless/irritable** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Sad** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |
| **Embarrassed** | 0 | 1 | 2 | 3 | 4 | 5 | ○ |