Atlantic ENT LLC | **Dr. Michael Widick, MD** | **Board Certified in Otolaryngology**

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PLEASE SIGN AND COMPLETE ALL PAPERWORK AND MAIL BACK IN THE PRE-STAMPED ENVELOPE ASAP.

THANK YOU

Please mail or drop-off COMPLETED paperwork 2 business days before your appointment

Dear New Patient,

Welcome to our practice. Your appointment with Dr. Michael Widick is scheduled for _____. This appointment is a consultation only. Dr. Widick will review with you your past medical history, current medications, discuss your ears, nose and throat problem and examine you. If Dr. Widick orders any tests or procedures, they will likely be scheduled for a future date. Should you need to cancel or reschedule your appointment, please call us a minimum of 48 hours in advance at 321-799-9797. Missed appointments will result in a $25 “no show fee” unless you notify the office 48 hours prior to your appointment.

We have enclosed a new patient registration form, medical history form, financial agreement and “HIPAA” privacy form for you to fill out and bring with you completed on the day of your appointment. These can be emailed to you as well. Please remember to bring your Insurance card(s), driver’s license and a list of your current medications so we can make a copy of them.

If your insurance has a co-pay and/or co-insurance, or if your deductible has not been met, payment is due on the day of service, prior to being seen by the doctor by methods of cash, check or credit card (Visa, Mastercard, Discover and American Express).

We look forward to seeing you!

Financial Policy and Agreement for Atlantic ENT LLC Atlantic Otolaryngology

We find that communication with our patients helps us in providing the best service to you. We have taken the time to provide information about the most commonly asked questions.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED;

We accept cash, personal checks, and major credit cards such as MasterCard, Visa, American Express, Discover (subject to change). Returned checks are subject to a service charge of $ 35.00 and you will lose your privilege to write a check to our office.

REGARDING INSURANCE:

The doctor service is provided directly to you and not to an insurance company. We cannot render service on the assumption that charges will be paid for you by the insurance company. If we participate with your insurance, we will file your services directly to them. You will be expected to pay any deductible and/or co pay/coinsurance as outlined in your policy when you check in on your appointment day.

AUTHORIZATION FOR SERVICES:

The patient is responsible for all authorizations for services before services are rendered. If we do not have an authorization number at the time of your visit, you can either pay for services or reschedule your appointment. Patients are also responsible for letting us know which lab their insurance requires us to use for any laboratory work otherwise you may receive a separate bill from a non-participating laboratory studies, imaging studies, etc.

SPECIAL NEEDS:

Special needs are understood by this office. It may be necessary to setup a payment plan for a patient requiring extensive treatment. If this situation arises, please bring it to our attention prior to treatment or immediately if treatment has already been initiated. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered. If we do not participate with your insurance company, payment will be required upfront at the time of your visit. We will file to your insurance company as a courtesy. If your insurance company pays, you will be issued a refund for the paid amount or it will be applied to any outstanding balance.

Thank you for taking the time to read this policy statement. We hope it answers your questions. If you have more questions, please let us know.

I have read and understand the above financial policy and agree to the terms as stated;

_____	_____
Patient Name (Please Print)	*Patient/Guardian Signature Date*

NEW PATIENT INFORMATION RECORD *(Please Print)*

PATIENTS NAME	SEX ☐M ☐F	MARTIAL STATUS ☐S ☐M ☐W ☐O ☐SEP	DATE OF BIRTH	AGE	PHONE

REASON FOR VISIT	SSN OF PATIENT

STREET ADDRESS	CITY AND STATE	ZIP CODE

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

SPOUSE'S NAME

SPOUSE'S EMPLOYER	EMPLOYERS ADDRESS	BUSINESS PHONE

NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU

FAMILY PHYSICIAN	REFERRING PHYSICIAN

IF THE PATIENT IS A MINOR OR A STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP	PHONE

MOTHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

FATHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP	PHONE

FATHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	POLICY NUMBER	INDIVIDUAL OR GROUP

POLICY HOLDER'S NAME	HOW LONG HAVE YOU HAD THIS INSURANCE?	SSN OF POLICY HOLDER	IF GROUP, EMPLOYER NAME

MAILING ADDRESS FOR INSURANCE CLAIMS

OTHER INSURANCE POLICIES

I authorize release of any medical information and payment of medical benefits to Dr. Widick.
I understand that even though I have some type of insurance coverage, I am responsible for payment of service.
I authorize release of my medical records to other health care professionals involved in my care.

Preferred Payment: Cash Check Credit Card Signature _____ Date _____

NOTICE: PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. IF YOU ARE UNABLE TO PAY OR MEET THE CONDITIONS OF YOUR INSURANCE PLAN, ASK TO SPEAK WITH THE FRONT DESK. SEE FINANCIAL POLICY / AGREEMENT REGARDING FILING INSURANCE CLAIMS, COLLECTING CO-PAYMENTS, DEDUCTIBLE AND AUTHORIZATIONS.

PATIENT HISTORY QUESTIONNAIRE *(Please Print)*

PATIENT NAME _____ DATE OF BIRTH _____

TODAY'S DATE _____

MAIN COMPLAINT

PLEASE LIST WHEN **YOU FIRST NOTICED** THESE SYMPTOMS (MONTH / YEAR)

HAVE YOU SEEN ANY **OTHER PHYSICIAN(S)** FOR THESE PROBLEMS? ☐ YES ☐ NO
IF YES, WHO?

HAVE YOU TAKEN **ANY MEDICATION** FOR THESE PROBLEMS? ☐ YES ☐ NO
IF SO, WHAT?

PLEASE LIST **ANYTHING** THAT MAKES YOUR SYMPTOMS **BETTER**

PLEASE LIST **ANYTHING** THAT MAKES YOUR SYMPTOMS **WORSE**

PLEASE INCLUDE ANY OTHER **CONTRIBUTING MEDICAL HISTORY**

PATIENT SOCIAL HISTORY *(Please Print)*

PATIENT NAME _____ Date of Birth _____

Email address _____ Today's Date _____

Height _____ Weight _____

PATIENT SOCIAL HISTORY

Present or Past Occupation _____ □ Retired □ Woodworker

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Alcohol: □ No, do not use
□ Yes, provide the number of drinks / week _____
□ Quit, Date you Quit

Tobacco: □ Never □ Cigarettes □ Cigars
□ 2nd Hand Smoke □ Chew/Snuff
□ Quit, complete below:
– Age you started tobacco use _____
– Date you Quit _____

Recreational Drugs:
□ Never
□ Marijuana
□ Other

Caffeine: □ No □ Yes, provide the number of drinks / week _____

Rate your **Lifestyle:**
□ Active □ Moderate □ Sedentary

Do you have a living will or Advanced Directive? □ No □ Yes, please list _____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family (parents/brothers/sisters) had... □ None of These

□ Alcoholism
□ Anemia
□ Angina (Chest Pain)
□ Arthritis
□ Allergies/Hay Fever
□ Bleeding Disorder
□ Birth Defects – type?
□ Cancer: _____
□ Diabetes
□ Ear - Hearing Loss
□ Ear - Deafness
□ Ear - Meniere's Disease
□ Ear - Otosclerosis
□ Epilepsy or Seizures
□ Glaucoma
□ Headaches
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Mental Illness
□ Stroke
□Thyroid Problem
□ Tuberculosis
□ Skin Cancer

Are you aware of any hereditary (familial) medical conditions in your family? □ No □ Yes, please list

PATIENT MEDICAL HISTORY

Do you have or have you ever had... □ **None of These**

□ AIDS/HIV
□ Alcoholism
□ Anemia
□ Angina/Heart Attack
□ Arthritis
□ Asthma
□ Thyroid Problem
□ Allergies/Hay Fever
□ Bladder Disease
□ Bleeding Disorder
□ Cancer:
□ Diabetes
□ Heart Disease
□ Epilepsy or Seizures
□ Glaucoma
□ Usual Childhood Illnesses
□ Ear - Hearing Loss
□ Ear - Noise Exposure
□ Ear - Trauma
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Hepatitis
□ Lung Disease
□ Mental Illness
□ Rheumatic Fever
□ Stroke
□ Trauma - Face
□ Trauma - Nose
□ Trauma - Head
□ Tuberculosis
□ Venereal Disease
□ Vertigo/whirling dizzy
□ Headaches
□ Skin Cancer
□ Ear Infections

Current Medications:

Preferred Pharmacy (with location/Zip Code):

Allergies (include reaction)

Hospitalization/Surgery (When/Why?)

USE BACK OF FORM IF NECESSARY □ Check here if back of form used.

PATIENT REVIEW OF SYSTEMS *(Please Print)*

Patient Name _____ Today's Date _____

Do you consider yourself generally: ◯ Healthy ◯ Fairly Healthy ◯ Not Healthy

Have you ever experienced or are you experiencing any of the following: (Please **check** all that apply)

EYES ☐None	☐Vision problems ☐Macular Degeneration	☐Glaucoma ☐Excessive Tearing	☐Cataracts ☐Other
EARS ☐None	☐Hearing Loss ☐Ear infections	☐Noise in ear(s) ☐Vertigo (spinning)	☐Pressure in ears ☐Ear drainage
NOSE/SINUS ☐None	☐Runny nose ☐Nose bleeds ☐Sinus pressure	☐Post-nasal drip ☐Loss of smell ☐Sinus Headaches	☐Nasal congestion ☐Facial pain ☐Chronic cough
ORAL CAVITY ☐None	☐Bruxism (Teeth Grinding) ☐Painful Teeth ☐	☐Sores in Mouth ☐Missing Teeth ☐Tongue Problems	Teeth condition: ☐Good ☐Fair ☐Poor ☐Dentures
PHARYNX (THROAT) ☐None	☐Infections ☐Pain swallowing	☐Difficulty swallowing food ☐	☐Difficulty swallowing fluids ☐
LARYNX (VOICE BOX) ☐None	☐Laryngitis ☐Change in voice	☐Cough when swallow ☐	☐Hoarseness ☐Vocal Cord Paralysis
NECK ☐None	☐Masses ☐Surgery	☐Radiation treatments ☐	☐Cysts ☐Thyroid Problems
CARDIOPULMONARY (HEART/LUNGS) ☐None	☐None ☐Cough	☐Chest Pain ☐Palpitations	☐Wheezing ☐Shortness of breath
GASTROINTESTINAL (STOMACH) ☐None	Appetite: Good Fair Poor	☐Difficulty swallowing	☐Heartburn/Acid indigestion or reflux
GENITOURINARY ☐None	☐Kidney infections ☐Recurrent UTI	☐Stones ☐Urinating at night	☐difficulty starting Urinary flow
MUSCULOSKELETAL ☐None	☐Serious injuries ☐Joint pains	☐Deformities ☐Arthritis	☐Loss of Strength
NEUROLOGIC ☐None	☐History of weakness ☐Imbalance	☐Numbness	☐Headaches
PSYCHIATRIC ☐None	☐Mood swings ☐Suicidal tendencies	☐Depression	☐Anxiety
INTEGUMENTARY (SKIN) ☐None	☐Skin Cancer ☐Unusual moles	☐Chronic irritation ☐Rashes/Hives	☐Itchy Skin
ENDOCRINE ☐None	☐Thyroid disorders ☐Hot Flashes	☐Hormone dysfunction ☐Heat susceptibility	☐Hair loss ☐Cold susceptibility
HEMATOLOGIC ☐None	☐Anemia (low blood count)	☐History of Swollen Glands	☐History of bleeding tendencies
ALLERGIC ☐None	☐Sneezing ☐Watery nose	☐Itchy Eyes ☐Itchy Nose	☐"Writable Skin" Atopic Dermatitis

MODIFIED EPWORTH SLEEPINESS SCALE *(Please Print)*

PATIENT NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____

SEX ◯ MALE ◯ FEMALE

How likely are you to dose off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing (0-3)**
Sitting and Reading	Click to select
Watching TV	Click to select
Sitting, inactive in a public place (e.g. a theatre or a meeting)	Click to select
As a passenger in a car for an hour without a break	Click to select
Lying down to rest in the afternoon when circumstances permit	Click to select
Sitting and talking to someone	Click to select
Sitting quietly after a lunch without alcohol	Click to select
In a car, while stopped for a few minutes in the traffic	Click to select

Do you Snore? ☐ YES ☐ NO

Have you been diagnosed with Obstructive Sleep Apnea? ☐ YES ☐ NO

Do you use a CPAP mask? ☐ YES ☐ NO

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

PATIENT NAME _____ SIGNATURE _____
(Please Print)

DATE OF BIRTH _____ SIGNATURE DATE _____

PATIENT'S ID / CHART NUMBER _____

For Personal Representative of the Patient (if applicable)

PRINT NAME OF PERSONAL REPRESENTATIVE _____

DESCRIBE PERSONAL REPRESENTATIVE RELATIONSHIP _____ (PARENT, GUARDIAN, ETC.)

SIGNATURE OF PERSONAL REPRESENTATIVE _____ DATE _____

For Practice Use Only:

_____

_____

_____

SIGNATURE OF PRACTICE EMPLOYEE _____ DATE _____