

OKLAHOMA EAR CLINIC & HEARING CENTER REGISTRATION

Jack E. Metcalf, M.D.

Please Print

Date _____

Patients Name _____ Sex: M F

Date of Birth _____ - _____ - _____ Age: _____ SSN: _____

Marital Status (Circle one) M S D W Race: _____

Patients Address: _____

City: _____ State _____

Zip _____

Home Ph: (_____) _____ Work Ph: _____

Cell/Pgr: _____

Referring Physician: _____

Phone: (_____) _____

Employer: _____

Occupation: _____

Work Address: _____

City: _____ ST: _____ Zip: _____

Spouse Name: _____ SSN: _____

Date of Birth: _____ - _____ - _____ Work Ph: _____

Spouse Employer: _____

Occupation: _____

Work Address: _____ City/ST/Zip: _____

Emergency Contact _____ Phone: (_____) _____

(Outside of Home)

Do you have Insurance? (check One) Yes _____ No _____

Please Present insurance card to Receptionist

Name of Primary Insurance: _____

Secondary: _____

Policy Holder Name _____ Policy Holder Name _____

Answer the following if patient is under the age of 21

Mother's Name: _____ SSN: _____

Mother's DOB: _____ - _____ - _____

Work Phone: _____

Employer: _____ Occupation: _____

Address: _____

Father's Name: _____ SSN: _____

Father's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Occupation: _____

Address: _____

Authorization for services/ Please read the following and sign at the bottom of this form

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am Responsible for any portion of my bill not covered by my insurance company, whether a co-pay, co-insurance, Deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also Understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices. You may read &/or download information on this web site or request a copy when you are in the office. This Acknowledges I have Received the Notice of Privacy Practices from my Provider.

Signature: _____ Date: _____

Financial Policy

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of financial policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the patient information form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered. We accept cash, checks, Visa or MasterCard.

Regarding Insurance:

The balance on your account is still your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided by the physician, an audiologist, or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance.

It is your responsibility to inform us if your insurance or your Physician/Provider changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

I, _____, have read the above
Print your name here
information and agree with the terms of the Financial Policy.

Signature: _____ Date ____/____/____

Release of Medical Information:

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by Surgical Specialists of Oklahoma, P.C. to the above named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes.

The information authorized for release may include records which may indicate the presence of a communicable or verbal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63OS 1.502.2

I also authorize you to accept a photocopy of this release and it shall have the same force and effect as if it were the original.

I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature: _____ Date ____/____/____

MEDICARE PATIENTS ONLY

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature: _____ Date ____/____/____

*****PLEASE COMPLETE ALL SPACES-DO NOT LEAVE ANY BLANKS*****

List your current physician(s) and their specialty _____

HAVE YOU HAD OR DO YOU HAVE:

- YES NO A Positive AIDS /HIV Blood Test
- YES NO Abnormal Bleeding Tendencies
- YES NO Acid Reflux
- YES NO Allergy Tests

Date _____ Results: _____

YES NO Anticoagulant Therapy (blood thinner)

YES NO Arthritis

YES NO Asthma

YES NO Ever Used Asthma Medication

Last time asthma medication used: _____

Asthma medications used: _____

YES NO Back Trouble

YES NO Blood Disease

YES NO Blood Transfusion

YES NO Blood Vessel Disease

YES NO Bronchitis

YES NO Chest X-ray in the Past Year

YES NO Chronic Lung Disease

YES NO Dental Caps or Bridges

YES NO Diabetes

YES NO Electrocardiogram in Past Year

YES NO Emphysema

YES NO Epilepsy or Seizures

YES NO False or Loose Teeth

YES NO Fracture of Facial Bones

YES NO Spine Problems What Kind? _____

YES NO Glaucoma

YES NO Hearing Loss

YES NO Heart Trouble: What Kind? _____

YES NO Hepatitis

YES NO High Blood Pressure

YES NO Hoarseness

YES NO Jaundice

YES NO Kidney Disease

YES NO Mononucleosis

YES NO Muscle Weakness

YES NO Paralysis

YES NO Pneumonia

YES NO Psychiatric or Mental Disorders

Circle One: Panic Attacks Depression

Describe: _____

YES NO Stroke

YES NO Thyroid Disease

YES NO Speech Problem

YES NO Seen Speech Therapy. Where? _____

Please list ANY Medical Problems, Hospitalizations, and/or Illnesses not listed above: NONE

Please list Any Medical Problems that run in your family: NONE

DO YOU:

Wear Contact Lenses **YES NO**

Use Tobacco **YES NO**

Drink Alcoholic Beverages **YES NO**

Use Illegal Drugs (Cocaine, Heroin, etc) **YES NO**

Object to a blood transfusion to save your life (if needed)

Reviewed & Updated

By: _____ Date _____ Weight _____ Allergies _____

By: _____ Date: _____ Weight _____ Allergies _____ Date _____

By: _____ Date _____ Weight _____ Allergies _____ Physician Reviewed: _____

By: _____ Date: _____ Weight _____ Allergies _____

YES NO Is there any other medical information? _____

PREVIOUS ANESTHETIC HISTORY:

Date of last anesthetic: _____

Any abnormal reactions? _____ YES NO

Relatives with abnormal reactions to Anesthetics YES NO

Comments: _____

PREVIOUS SURGERY HISTORY: If YES give date of surgery

YES NO Hernia _____

YES NO Joint Surgery ___ What Kind? _____

YES NO Gallbladder _____

YES NO Hysterectomy _____

YES NO Heart Bypass _____

YES NO Angioplasty _____

YES NO Sinus Surgery _____

YES NO Nasal Surgery _____

YES NO Cosmetic Surgery _____

YES NO Tonsillectomy _____

YES NO Ear Surgery _____

YES NO Ear Tubes _____

YES NO Adenoidectomy _____

If any other surgeries, Please list: _____

CURRENT MEDICATIONS:

Prescriptions: _____

Non-Prescriptions: _____

Herbal Remedies: _____

ALLERGIES:

Drug: _____

Describe the allergic reaction: _____

Food or Other: _____

IF FEMALE OF CHILDBERING AGE:

Are you pregnant? Yes No

AGE: _____ **Approx. Weight:** _____

Patient's Name

Patient/Guardian Signature

Adult's Ear History

NAME: _____

DATE: ____/____/____

Please take a few minutes to fill out this questionnaire completely. This will help your doctor be more complete in determining the cause and extent of your problem.

What is the main problem (symptom) you have with your ear/s?

How does it bother you?

Please write below in your own words what has occurred since this began:

Location: which ear?

Severity:

Quality:

Timing:

Associated Sx:

Improved by:

Worsened by:

2. How long have you had this problem?

3. List other doctors you have seen for this problem:

Date	Practitioner	Diagnosis	Treatment or Medication
1. _____	_____	_____	_____
2. _____	_____	_____	_____

4. List any medications you are taking for your ear problem now

Have you had or do you have:

Yes	No	Do you have a hearing problem? Please Describe
Yes	No	One ear that hears worse than the other ear? Which ear is worse?
Yes	No	Ringing or noise in your right ear? How long have you had the noise?
Yes	No	Ringing or noise in your left ear? How long have you had the noise? How would you describe the noise?
Yes	No	Do you have a balance problem? Please describe
Yes	No	Exposure to loud noise during your lifetime? What kind of noise ?
Yes	No	Ear infections Right ear Left ear When?
Yes	No	Ear Trauma Right ear Left ear What kind of injury?
Yes	No	Hole in your eardrum Right ear Left ear When?
Yes	No	Is the hole still in your eardrum as far as you know?
Yes	No	Excessive itching of your ear canals Right ear Left ear
Yes	No	Do you have ear pain now? Right ear Left ear Describe the pain:
Yes	No	Ear surgery Right ear Left ear What was the surgery? Who did the surgery? When was the surgery?
Yes	No	Does anyone in your family have hearing problems? Who
Yes	No	Has anyone in your family had ear surgery? Who What was done?
Yes	No	Do you wear hearing aids? Right ear Left ear How old are you current aids? Are you happy with your current aids? Who fitted your current aids?
Yes	No	Is there any more information that you would like me to know?