

**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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# CHILDREN'S EAR HISTORY

NAME \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ M D GM GF A U

Please answer the questions below. I know you may not be exact, but approximate dates and times will help a lot. I can always get exact information if necessary from your doctor or pharmacy. I would like for you to start with recent events and work your way back.

1. What is the main problem your child is having that requires you to consult me? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. When was the last time your child was seen for this problem? \_\_\_\_\_
3. Who did the examination? \_\_\_\_\_
4. What did they say? \_\_\_\_\_  
\_\_\_\_\_
5. How did they describe the ears? Right? \_\_\_\_\_  
Left? \_\_\_\_\_
6. List the last antibiotic given \_\_\_\_\_ When was it started? \_\_\_\_\_  
When was it finished? \_\_\_\_\_
7. Did they recommend you see an ENT doctor? Yes No
8. Did they say anything else? \_\_\_\_\_
9. Has there been any hearing problem noted? Yes No \_\_\_\_\_
10. Is the speech and language development ok? Yes No \_\_\_\_\_
11. When did the ear infections/fluid start (an approximate age or date)? \_\_\_\_\_
12. Have they caused the child to be very sick or has the degree of pain and fever been mild? Yes No
13. How many ear infections have there been in the last 6 months? \_\_\_\_\_
14. How many antibiotics have been used in the last 6 months? \_\_\_\_\_
15. Has there been a problem with both ears or just one? \_\_\_\_\_
16. Can you list any antibiotics that have been used to treat the ear? Please circle if used in the last 6 months.  
Amoxil Augmentin Ceftin Cefzil Zithromax Cedax Suprax Omnicef  
Bactrim Septra Gantrisin Vantin Shots Other \_\_\_\_\_
17. Are there any symptoms the last 1-2 days? Please circle current symptoms below:  
Fever When was the last temperature and how high was it? \_\_\_\_\_  
Pulling at ears digging at ears fussy cranky poor sleeping  
Runny nose what color was the drainage? \_\_\_\_\_
18. Are there any other symptoms recently? Please list \_\_\_\_\_
19. Has anyone in your family had (if yes, list who): \_\_\_\_\_  
Yes No Frequent Ear Infections \_\_\_\_\_  
Yes No Ear Tubes \_\_\_\_\_  
Yes No Poor hearing \_\_\_\_\_  
Yes No Asthma \_\_\_\_\_  
Yes No Allergies \_\_\_\_\_  
Yes No Is the child exposed to cigarette smoke?  
Yes No Is the child exposed to other children during childcare?  
Yes No Have other specialists seen your child? Please list \_\_\_\_\_  
Yes No Have any tests been done? Please list \_\_\_\_\_  
Is there anything else you would like me to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CHILDREN'S HEARING HISTORY EVALUATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PLEASE CIRCLE YES OR NO FOR EACH QUESTION BELOW

YES NO Did your child have a low birth weight? \_\_\_\_\_

YES NO Did your child have a low apgar score at birth, 0-3 at 5 minutes, or fail to breath on his own?

YES NO Was your child on a ventilator?

YES NO Has your child ever had meningitis?

YES NO Does your child have any birth marks? \_\_\_\_\_

YES NO Does anyone in your family have a hearing loss? \_\_\_\_\_

YES NO Does your child have any birth defects? \_\_\_\_\_

YES NO Did your child have hyperbillirubinemia that required a blood transfusion?

YES NO Does your child have any delays in development? \_\_\_\_\_

YES NO Has your child ever had a head injury?

YES NO Has your child ever the measles or the mumps?

YES NO Did you have any problems with your pregnancy? \_\_\_\_\_

YES NO Did your child have to stay in the neonatal intensive care unit after birth?

YES NO Has your child ever had a very high fever?

YES NO Has your child ever received I.V. antibiotics for more than five days?

YES NO Do you feel your child has a hearing loss?

YES NO Will your child startle to loud sounds?

YES NO Has your child ever had toxoplasmosis, rubella, cytomegalovirus, or herpes?

YES NO Has your child complained about ringing or roaring in his/her ears?

YES NO Has your child complained about being dizzy?

YES NO Has your child had many ear infections?

YES NO Has your child had ear tubes placed in his/her ears or any other surgery?

YES NO Is your child currently taking medication for his/her ears?

If yes, what is it? \_\_\_\_\_

YES NO Does your child have trouble in school?

YES NO Do you feel like your child has difficulty with his/her speech and/or language?

YES NO Did you child have a hearing test at their birth hospital? Pass or Fail

YES NO Has your child ever had any other type of hearing testing?

When? \_\_\_\_\_

Where? \_\_\_\_\_

Results? \_\_\_\_\_

Please record any other information/comments that you want me to know.

\_\_\_\_\_