Shipman ENT & Associates

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Board certified experience. Leading edge solutions

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill the following form out as completely as possible. This is very important information. Please fill out every item! It is important for your doctor to know that you have carefully reviewed every area. This information will be entered into the computer and you are welcome to a copy of the report if you wish. **Please print carefully and clearly** so we can correctly read your information!

Full Name: _____Sex: ____ Male ____ Female

Mailing and/or Physical Address: (write full address incorporating your street, city, state, and zip)

_____

_____

Phone: (_____) _____-_____ Home: ____ Cell: ____ Work: ____ Other: _____

Phone: (_____) _____-_____ Home: ____ Cell: ____ Work: ____ Other: _____

Phone: (_____) _____-_____ Home: ____ Cell: ____ Work: ____ Other: _____

Date of Birth: _____ Social Security Number: _____

Height: _____ Weight: _____ Race: _____

Email: _____ Preferred Language: ____ English ____ Spanish

Primary Insurance

Carrier/Provider: _____

Insured Identification Number: _____ Policy Group: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Secondary Insurance

Carrier/Provider: _____

Insured Identification Number: _____ Policy Group: _____

How did you hear about our office?

_____ Billboard _____ Newspaper _____ Yellow Pages _____ Internet Search _____ Television

_____ Patient: (their name) _____

_____ Physician: (their name) _____

Primary Care Physician: _____

Your Pharmacy Name & Location: _____

Our EMR allows us to view your medication list from your pharmacy. This will allow us to input the correct medication(s) and dosage into your chart.

Please check whether or not you will allow us to view your medication list from your pharmacy.

- ❑ **Yes**
- ❑ **No**

Disclosures to family, loved-ones and friends who have supporting role in your health care and/or treatment. This practice will comply with your request to share personal health information with person(s) listed below for test results, picking up prescription, equipment, directions or other items associated with your care. Please list person(s) and relationship.

Name	Relationship	Contact Number:
_____	_____	_____
Name	Relationship	Contact Number:
_____	_____	_____
Name	Relationship	Contact Number:
_____	_____	_____

Patient Signature: _____

Are you taking ANY kind of Medication now? This includes prescription, over-the-counter medication (such as aspirin or herbal medications)

- ❑ No.
- ❑ Yes.

Current Medications

Please list any prescription, over-the-counter, and/or herbal medications that you are currently taking.

Medication and strength	How often taken?	Problem being treated	Prescribing Doctor

Are you allergic to any form of medication?

- ❑ No.
- ❑ Yes. Please complete the form below.

Name of Medication	Type of reaction (nausea, hives, etc)

Are you allergic to any non-medical allergens, such as pollens, dust, food, etc?

- ❑ No.
- ❑ Yes. Please complete the form below.

Name of Irritant	Type of reaction (nausea, hives, etc)

Have you ever had a formal allergy test (either skin test or blood test)?

- ❑ No.
- ❑ Yes. What type of test did you have?
  - ☐ Skin test: What year? _____
  - ☐ Blood test: What year?_____

  Where any of the tests positive?
  - ☐ No.
  - ☐ Yes. Please list all the things you were allergic to.

    _____

    _____

Have you ever taken allergy desensitization shots?

- ❑ No.
- ❑ Yes. When did you start and stop the shots (please give year or age)

  Started: _____ Stopped: _____

Were the shots helpful?

- ❑ No
- ❑ Yes

Please indicate which of the following childhood diseases you have had.

- ❑ Chickenpox
- ❑ Haemophilus Influenzae B
- ❑ Hepatitis B
- ❑ Measles (Rubeola)
- ❑ Measles, German (Rubella)
- ❑ Mumps
- ❑ Scarlet Fever
- ❑ Strep Throat
- ❑ Whooping Cough (Pertussis)
- ❑ Other: _____

Have you ever been diagnosed with a health problem other than simple things like the common cold? We particularly need to know about problems such as diabetes, heart troubles, high blood pressure, cancer, lupus, etc.

- ❑ No, I have never had a serious medical problem diagnosed.
- ❑ Yes, I have had problems diagnosed. If yes, please list below.

Health problem that has been diagnosed	Month and Year

Have you ever had any problems with anesthesia such as fever, trouble waking up, or problems with your throat after surgery?

- ❑ No.
- ❑ Yes. Please list what sort of problems that you experienced.

_____

_____

Have you ever had an operation?

- ❑ No.
- ❑ Yes. List all operation, including childhood that you have had and the date of the operation.

Type of surgery	Month and Year

Have you ever been hospitalized for a medical problem not requiring surgery?

- ❑ No.
- ❑ Yes. List all reasons for admission and the date and/or your age at the time.

Reason For Hospitalization	Date of Hospitalization

Have you ever had a serious accident or injury?

- ❑ No.
- ❑ Yes. List the type of injury and the year or age at which it occurred below.

Type of injury	Month and Year

Immunizations - Have you been immunized?

- ☐ No.
- ☐ Yes.

Are your immunizations up to date?

- ☐ No.
- ☐ Yes

Have you had an Influenza Vaccine/Flu Shot?

- ☐ No.
- ☐ Yes. **If yes please include month & year** _____

Have you had the following Diagnostic/Screening Tests? (If yes, month and year is needed to the best of your knowledge)

- ❑ Colonoscopy_____
- ❑ Fecal Occult Blood Testing _____
- ❑ Mammography_____
- ❑ Pap smear_____
- ❑ Sigmoidoscopy-Flexible_____

Family History

Parent's Health Status:

Mother's Health Status: ☐ Excellent ☐ Good ☐ Poor ☐ Deceased ☐ Unknown
If living, please write her current age: _____
If deceased, please write the cause and age of death: _____

Father's Health Status: ☐ Excellent ☐ Good ☐ Poor ☐ Deceased ☐ Unknown
If living, please write his current age: _____
If deceased, please write the cause and age of death: _____

Has anyone in your immediate family had a severe reaction to anesthetic?

- ❑ No.
- ❑ Yes. List the family member who had a reaction and what happened.

Type of reaction	Family member

Are there any other problems that seem to run in your family? It is most important to think of serious problems such as diabetes, heart problems, cancer, hearing loss, etc.

- ❑ No.
- ❑ Yes. Please list problems or disorders that run in your family and which family member(s) have/had the problem.

Health Problem	Family Member

Social History

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Have you ever used tobacco in any form? ☐ No ☐ Yes
Do you currently use tobacco in any form? ☐ No ☐ Yes
If yes to any of the two, please answer the following.

Type of tobacco	**Amount**
Cigarettes per day	
Pipes of tobacco per day	
Chews of tobacco per day	
Cigars per day	

Have you ever drunk alcoholic beverages? ☐ No ☐ Yes
Do you currently drink alcoholic beverages? ☐ No ☐ Yes
If yes to any of the two, please answer the following.

Type of beverage	**Amount**
Cans/Bottles of beer per week	
Glasses of wine per week	
Wine coolers per week	
Mixed drinks or shots of liquor per week	

Do you use drugs recreationally?
- ❑ No
- ❑ Yes. Please list the drug(s): _____

Are you now or have you ever been dependent or addicted to any drug, including alcohol?
- ❑ No
- ❑ Yes. Please list the drug(s):_____

Do you drink caffeinated beverages, such as tea, coffee, Coca-Cola, etc?
- ❑ No
- ❑ Yes. Please select the answer below that applies best to you.
  - ❑ 1 caffeinated drink per day
  - ❑ 2-3 caffeinated drinks per day
  - ❑ more than 4 caffeinated drinks per day

Are you exposed to second-hand smoke?
- ❑ No
- ❑ Yes

What is your living situation?
- ❑ Live alone
- ❑ Live with spouse
- ❑ Live with children
- ☐ Live with parents
- ☐ Live with roommates
- ☐ Live in a nursing home
- ☐ Other: _____

Problems in your body that you feel or see—do not put a diagnosis here. For instance, if you have problems with headaches that have been diagnosed as migraines, put only headache here.

Do you feel and/or see a problem with your eyes other than a problem that can be corrected with glasses/contacts? Example: itchy eyes, double vision, inflammation, etc.

- ❑ No
- ❑ Yes. Please list the problem(s) below.

Problem	Duration

Do you feel and/or see a problem in your ears, nose, mouth and/or throat?

- ❑ No
- ❑ Yes. Please list the problem(s) below. Example: ear pain, drainage, snoring, sore throat, etc.

Problem	Duration

Please look at the following items listed below. These can be related to chest, heart, and/or lung problems. Do you have any of these problems? Look closely before answering.

- ❑ No
- ❑ Yes.

  - ❑ Blacking out or fainting
  - ❑ Bluish discoloration of the lips or nails
  - ❑ Chest pain or discomfort at rest
  - ❑ Chest pain or discomfort with exercise
  - ❑ Cold hands or feet
  - ❑ Enlarged veins in the legs
  - ❑ Heart Murmur
  - ❑ Irregular heartbeat or feeling of fast pounding heartbeat
  - ❑ Leg cramps or pain in legs when walking short distances
  - ❑ Lightheadedness or near fainting
  - ❑ Shortness of breath just when lying down
  - ❑ Shortness of breath when sitting or standing
  - ❑ Suddenly waking up short of breath at night
  - ❑ Swelling (including the ankles)

Do you feel and/or see a problem with your abdomen or bowel habits?

- ❑ No
- ❑ Yes. Please list the problem(s) below. Example: abdominal pain, diarrhea, etc.

Problem	Duration

Do you feel and/or see a problem with urination, or menstrual (female) problems?

- ❑ No
- ❑ Yes. Please list the problem(s) below.

Problem	Duration

Do you feel and/or see a problem with your bones, joints, or muscles?

- ❑ No
- ❑ Yes. Please list the problem(s) below. Example: pain, stiffness, numbness, etc (specify where)

Problem	Duration

Do you feel and/or see a problem with your integumentary (skin, breast, hair, nails)?

- ❑ No
- ❑ Yes. Please list the problem(s) below. Example: itching, blisters, hair loss, etc.

Problem	Duration

Do you have Neurological (brain and nervous system) problems?

- ❑ No.
- ❑ Yes. Please list the problem(s) below. Example: headaches, seizures, numbness, etc.

Problem	Duration

Do you have any Psychological (mental and/or emotional) problems?

- ❑ No.
- ❑ Yes. Please list the problem(s) below. Example: anxiety, depression, etc.

Problem	Duration

Do you have fever, aching, fatigue or anything else that you can feel or see that you have not already described?

- ❑ No
- ❑ Yes. Please describe: _____

Do you bleed too easily?

- ❑ No
- ❑ Yes

Do you bruise easily?

- □ No
- □ Yes

Do you have lumps in your neck, armpits, groin, or elsewhere?

- ❑ No
- ❑ Yes. Please list where: _____

Other comments: _____

_____

Important Clinic Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible, we adhere to setup very important guidelines to ensure the highest quality of care for all patients. Please read them carefully, **initial all the boxes**, and indicate your agreement by signing the form at the bottom. **We look forward to building a successful relationship with you that lasts a lifetime.**

☐ **Late Policy " 10 minutes"**

Being late by more than **10 minutes** will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this compromises the care of another patient.

☐ **24- Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice.** Anything less will result in a **$25 fee** charged to your account. It cost money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a small fee. We do NOT make money with this charge; it is only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we will be able to see you without payment **one time.** However, if it occurs more than once, we will require a credit card number to be placed in your file for future occurrences.

☐ **No- Shows are Bad**

If you fail to show for an appointment without notice a **$25 fee** will be assessed to your account. You may re-schedule appointments again on a "first come, first serve basis"

☐ **Cell phones must be turned OFF or silent**

We realize emergencies may arise and thus you may need to carry your cell phone during your treatment session, however, please be courteous & set it to silent mode or turn it off during treatment. Thank you.

I have read & agree to all of the above policies.

Signature _____Date_____

CONSENT FOR MEDICAL TREATMENT AND INSURANCE BENEFITS

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Shipman ENT and Associates (hereafter referred to as Shipman ENT) will maintain a record of the care and services you receive at Shipman ENT. This consent only covers your protected health information created while you are a patient of Shipman ENT. Your protected health information pertains to your diagnosis and/or treatment at Shipman ENT, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Shipman ENT's use and/or disclosure of protected health information about you for treatment, payment, health care operations (TPO), and as otherwise allowed by law. Our *Notice of Health Information Practices* provides information about how Shipman ENT may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and give my consent for medical treatment and procedures by Nolan D. Shipman, M.D., and certify that no guarantee or assurance has been made as to the result which may be obtained.

CONSENT TO RELEASE MEDICAL RECORDS

This consent will authorize Nolan D. Shipman, M.D. to provide a copy, summary or narrative of my medical records to my referring physician(s), insurance company, and/or workers compensation carrier (if applicable).

CONSENT TO RELEASE MEDICAL RECORDS

I hereby allow Dr. Nolan D. Shipman to obtain medical records from any hospital or any past physicians, as he feels necessary. This would include both previous testing and current evaluations, which he or other physicians may have ordered.

CONSENT REGARDING INSURANCE BENEFITS

For hospital or office services provided (if applicable), I hereby authorize Shipman ENT & Associates to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, employer, or other provider of services. I understand my insurance coverage is a contract between myself and the insurance company. I hereby assign and transfer to Shipman ENT & Associates my rights and benefits due from my insurance companies provided for on the new patient information sheet. I hereby agree to update Shipman ENT & Associates should my insurance coverage change. I hereby understand that ultimate financial responsibility for all medical services performed by Shipman ENT & Associates lies with me.

MANAGED CARE WAIVER

I understand that, in the opinion of Dr. Nolan D. Shipman, the services that I have requested to be provided to me may not be covered by Medicare, my commercial insurance, or my managed health care plan. If my charge(s) is (are) determined by my insurance carrier to be outside of my network, or not a covered charge, I understand that I will be responsible for payment for these services because they are reasonable and medically necessary for my care.

We appreciate you choosing our practice and want to ensure your understanding of our payment policy prior to receiving professional services. It is our policy to file all insurance claims the same day services are rendered. If you have coverage with a managed care plan, it is your responsibility to find out if Dr. Shipman is a participating provider with your plan.

OFFICE POLICIES

New Patient Forms:
If you can have them faxed prior to your appointment, we ask that you arrive 10 minutes early. If you decide to bring them with you, we ask that you arrive 15 minutes early so we may enter all information into our system before being seen by Dr. Shipman. If you are unable to be here 15 minutes early, we ask that you call to reschedule your appointment. Please be prepared to present your insurance card(s) and your driver license.

Office Visits:
Forms will need to be filled out each time you visit the office, we ask that you arrive 5 minutes prior to your appointment. You, the patient, are responsible for keeping us up-to-date with your latest insurance information. Co-pays, co-insurance or deductibles are required to be paid at the time of service.

All CPAP patients must have their data card downloaded prior to their appointment. If you bring the card with you the day of your appointment, your scheduled appointment may be rescheduled or you will be seen as soon as we are able to download your card, which may be a later time then what you were scheduled for.

All thyroid patients will need to have their blood drawn one week prior to their visit. If you do not have your blood work drawn we will reschedule you**. No refills on thyroid medication will be given without seeing Dr. Shipman first.**

Returned Checks:
There will be a $25.00 service charge for returned checks. All uncollected returned checks will be turned over the County Attorney for prosecution.

Insurance Disputes:
It is your responsibility to know the terms and coverage of your specific insurance plan. You, the patient are responsible for paying for services rendered to you by Dr. Shipman. If your insurance company chooses not to cover our services, payment remains your responsibility. It is your responsibility to contact your insurance carrier to dispute lack of payment on their part.

Statements for your balance are mailed each month:
If you are unable to pay your account in full, please contact our billing office to make arrangements for a payment plan. There will be a $25.00 penalty for any billing cycle in which no payment is made. If it becomes necessary to turn your account over to a collection agency, a fee will be added to cover the cost charged by the collection agency. You agree to pay for any fee associated with the collection of an unpaid balance.

Medical Records:
The Texas Medical Board allows a set charge for copying medical records. There is a $25.00 charge for 20 pages or less, and $0.50 per page after the first 20. Shipping or mailing cost will be added to the fee. This must be paid prior to release of the records unless requested by a health care provider for “acute” or “emergency” care.

Telephone Calls:
Our nursing staff assists the doctor in the office every day. If they are not able to take your call immediately you will be transferred to their voicemail and we ask that you please leave a message with a number that you can be reached at after 6pm. The nurse will call you as soon as they become available which my be after 6pm.

Office Hours

Monday – Thursday	**8:00AM-12:00PM 1:00PM–6:00PM**

Allergy Hours

Monday & Wednesday	**8:15AM-11:45AM 1:15PM- 5:45PM**
Tuesday & Thursday	**8:15Am-11:45AM 1:15PM- 4:45PM**

By signing this form you acknowledge that you have received a copy of Shipman ENT's CONSENT FOR MEDICAL TREATMENT AND INSURANCE BENEFITS and Shipman ENT's PAYMENT POLICY. Please take the opportunity to review both before signing this consent. Please assure that you have read our Privacy Policies.

_____

Signature of Patient or Legal Representative Date

_____

Witness Signature Date

Thank you so much for taking the time to fill out these forms.
We greatly appreciate it!
~Shipman ENT Staff