AOC
HEAD & NECK
SURGEONS

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MESA OFFICE
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Mesa, Arizona 85202
Phone (480) 539-4000
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I, _____ DOB: _____, give permission to AOC Physicians to release my medical records and share any and all medical information, including but not limited to: test results, billing information, referrals, appointments and medication requests, with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I give AOC permission to leave a message regarding my medical information: (pick on)

NO / **YES** at the following phone number: _____

NOTICE:

By signing this form I understand that in accordance with HIPAA privacy regulations we can only release information to persons listed above and leave messages on the phone number indicated on this form. We CANNOT accept verbal authorizations. Thank you.

I understand that I have the right to revoke this release in writing at any time.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

Arizona Otolaryngology Consultants, PC (AOC) Physician:_____

Coordination of Benefits Questionnaire

Do you, or any member of your family, have any other coverage under any other group insurance, HMO of Medicare or AHCCCS coverage? Please place a check after the appropriate answer.

YES_____ If you answer yes, please complete the following information

NO_____ If you answer no, please sign this questionnaire

Insurance Company Name_____ Phone Number_____

Insurance Company Address_____

Name of Policy Holder_____

Policy Number_____ Group Number_____

Signature*_____ **Date**_____

* Consent for Use of Disclosure Information for Purposes Requested by Physician's Office *

I hereby permit Arizona Otolaryngology Consultants, PC to use my health information, and/or to disclose my health information to any third party payer, or to any party involve in my healthcare.

I understand that there is a Notice of Privacy Practices posted in the practice reception area available for me to read.

This consent shall be in force and effect as long as I am a patient at this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician (s) at this practice.

I also understand that I have a right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal Law (or state law to the extend the state law provides greater access rights).
- Refuse to sign this authorization *Refusal to sign will result in cancellation of your appointment.

*_____

Signature of patient or personal representative **Date**

_____

Printed name of patient or personal representative **Description of personal representative's authority**

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as **"Surgery"** and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

Flexible laryngoscopy: This procedure involves passing a long thin flexible fiberoptic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue.

Please speak with our nurse or clinical assistants if you have any questions.

*_____

Patient Signature **Date**

ARIZONA OTOLARYNGOLOGY CONSULTANTS
Dr Manikandan Sugumaran
Patient Health History Form

Patient Info:

Patient Name:_____ Age:_____Date of Birth_____

Name of physician requesting this consultation:_____

Name of Primary Care Physician:_____

Have you or a family member been seen by any other physician in this practice:_____If yes, by whom?_____

Patient History:

Description of problem:_____

How long have you had this problem?_____

1. Do you have any of the following medical conditions or symptoms? Circle yes (Y) or no (N)

General
Y/N Weight loss
Y/N Weight gain
Y/N Fatigue
Y/N Night sweats
Eyes:
Y/N Double vision
Y/N Vision loss
Ears:
Y/N Hearing loss
Y/N Ringing in your ears
Y/N Ear drainage
Nose:
Y/N Congestion
Y/N Drainage from nose
Y/N Sinus infections
Y/N Nose bleeds
Throat:
Y/N Throat infections
Y/N Difficulty swallowing
Y/N Cough

Cardiovascular
Y/N Chest pain
Y/N Heart attack
Y/N High blood pressure
Y/N Irregular heartbeat
Y/N Heart murmur
Respiratory:
Y/N Asthma
Y/N Blood in sputum
Y/N TB
Y/N Pneumonia
Y/N Sleep apnea
Y/N Snoring
Y/N COPD/Emphysema
Y/N Noisy breathing
Gastrointestinal:
Y/N Barrets esophagus
Y/N Heartburn
Y/N Ulcers
Y/N Hepatitis
Y/N Jaundice

Genitourinary:
Y/N Kidney or Bladder disease
Y/N Prostate problems
Neurological:
Y/N Hand tremor
Y/N Seizures
Y/N Stroke
Y/N Parkinson's
Y/N Alzheimer's
Y/N Headaches
Endocrine:
Y/N Diabetes
Y/N Thyroid disease
Allergy/Rheumatology
Y/N Sneezing, itchy eyes/nose
Y/N Skin rashes/eczema
Y/N Autoimmune (Sarcoid. Wegener's, SLE , etc)
Hematology:
Y/N Blood clots
Y/N Easy bruising or bleeding
Y/N Psychiatric Illness

Cancer (please list type, date of diagnosis and treatments):_____

2. Please list **all** of your past medical problems:_____
_____
3. Please list any previous surgeries you have undergone: (including non ENT procedures)_____
_____
4. Please list any family history of any medical conditions: _____
_____
5. Please list any ENVIRONMENTAL or MEDICATION allergies:_____
_____
6. Please list all medication you are taking, including over the counter meds, and supplements (Include dosages):

Medication	Dosage	Medication	Dosage	Medication	Dosage	Medication	Dosage
1.		5.		9.		13.	
2.		6.		10.		14.	
3.		7.		11.		15.	
4.		8.		12.		16.	

Social History:

7. Do you or did you ever smoke?_____. If yes, how much?_____. Have you quit?_____- When?_____
8. Do you drink alcohol?_____. If yes, how much?_____
9. How much caffeine do you drink?_____

Surgical Risk:

1. Have you or any family member had any adverse reaction to anesthesia?_____ If yes, specify: _____
   _____
2. Do you or any family member have any history of bleeding problems?_____ If yes , specify: _____
   _____

Complete the following sections if being seen for a voice/laryngeal problem

Vocal History:

1. In what capacity do you use your voice? Check all that apply

O Singer	O Announcer	O Sales	O Clergy
O Actor	O Teacher	O Politician	O Parenting
O Radio	O Physician	O Social	O Lawyer
O Telephone	O Other (Please Specify)		

2. Have you had any of the following symptoms? Answer yes (Y) or no (N):

Y/N Hoarseness	Y/N Sensation of acid reflux in throat	Y/N Throat clearing
Y/N Frequent sore throat	Y/N Vocal Fatigue	Y/N Pain while speaking
Y/N Choking sensation	Y/N Voice worse in morning	OTHER:_____

3. Singers only:
   Have you had any loss of range? _____ If yes, Specify:_____
   Do you require prolonged warm-up?_____

VOICE HANDICAP INDEX (VHI-10)

Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

F 1. My voice makes it difficult for people to hear me.	0	1	2	3	4
P 2. I run out of air when I talk.	0	1	2	3	4
F 3. People have difficulty understanding me in a noisy room.	0	1	2	3	4
P 4. The sound of my voice varies throughout the day.	0	1	2	3	4
F 5. My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
F 6. I use the phone less often than I would like to.	0	1	2	3	4
E 7. I'm tense when talking to others because of my voice.	0	1	2	3	4
F 8. I tend to avoid groups of people because of my voice.	0	1	2	3	4
E 9. People seem irritated with my voice.	0	1	2	3	4
P 10. People ask, "What's wrong with your voice?"	0	1	2	3	4