AOC
HEAD & NECK
SURGEONS

PHOENIX OFFICE
2222 E. Highland Suite 204
Phoenix, AZ 85016
Phone (602) 264-4834
Fax (602) 254-5178

SCOTTSDALE OFFICE
6565 E. Greenway Pkwy.
Suite 101
Scottsdale, AZ 85254
Phone (480) 948-2056
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AHWATUKEE OFFICE
4545 E. Chandler Blvd.
Suite 202
Phoenix AZ 85048
Phone (480) 659-2330
Fax (480) 659-2544

GLENDALE OFFICE
5750 W. Thunderbird Rd.
Suite A-100
Glendale, AZ 85306
Phone (602) 938-3205
Fax (602) 938-5799

MESA OFFICE
1520 S. Dobson Rd.
Suite 305
Mesa, Arizona 85202
Phone (480) 539-4000
Fax (480) 539-7033

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**

Back Office Use Only
Height: _____
Weight: _____

Health History Questionnaire

Patient Name:_____ **Date**:_____ **Birth Date**:_____ **Age**: _____

Referring Physician:_____ **PCP**:_____

Reason for visit:_____

_____

_____

Have any family members been seen by AOC: Yes ☐ No ☐ Name: _____

Date symptom first appeared:_____ Did it begin ___ Gradual ___ Sudden ___ Progressed over time

Medications (including aspirin and other non-prescription drugs)	Dose	Frequency
Allergies (Medications,Anesthetics,Materials)	**Surgeries/Hospitalizations**	**Year**

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes - pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
	If the patient is under the age of 18, is there exposure to tobacco smoke?			☐ Yes	☐ No
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Drugs	Do you use any drugs not listed above?			☐ Yes	☐ No
	If yes, please list: _____				
Diet	Do you have any dietary limitations?			☐ Yes	☐ No
	If yes, please list: _____				
Immunizations	Are immunizations complete and up to date?			☐ Yes	☐ No
Family History	Have you had any trouble with anesthesia?			☐ Yes	☐ No
	Do you have a family history of trouble with anesthesia?			☐ Yes	☐ No
	Do you have a family history of easy bleeding?			☐ Yes	☐ No
	Any complications with pregnancy, birth, or delivery?			☐ Yes	☐ No

PLEASE DO NOT WRITE HERE – PHYSICIAN USE ONLY

Physician Signature _____

Patient Name: _____

Date of Birth: _____

Are you currently, or have you had, problems with:

	Check One	
Ears, Nose, Throat, & Mouth	**Yes**	**No**
Hearing Loss	☐	☐
Noise/Ringing in the ears	☐	☐
Sore throat	☐	☐
Trouble swallowing	☐	☐
Hoarseness	☐	☐
Nasal congestion	☐	☐
Nose bleeds	☐	☐
Nasal drainage	☐	☐
Nasal fracture	☐	☐

☐ Left ☐ Right ☐ Both ☐ Family History

☐ Left ☐ Right ☐ Both ☐ Family History

☐ Family History

☐ Family History

☐ Family History

☐ Family History

☐ Family History

☐ Family History

Please explain how fracture occurred: _____

_____

Eyes

Double vision	☐	☐
Visual loss	☐	☐

☐ Left ☐ Right ☐ Both ☐ Family History

Constitutional

Weight gain	☐	☐
Weight loss	☐	☐
Night sweats	☐	☐

Cardiovascular	**Yes**	**No**
Chest pain or angina	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Irregular heartbeat	☐	☐

Name of Cardiologist:_____

Neurological

Seizures	☐	☐
Stroke	☐	☐
Headache	☐	☐

Name of Neurologist:_____

Psychiatric

Depression	☐	☐

Respiratory

Asthma	☐	☐
Cough up blood	☐	☐
TB	☐	☐
Pneumonia	☐	☐
Sleep Apnea	☐	☐
Snoring	☐	☐
Emphysema/COPD	☐	☐

Name of Pulmonologist:_____

Gastrointestinal	**Yes**	**No**
Indigestion/Heartburn	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐

Genitourinary		
Prostate disease	☐	☐
Kidney or bladder trouble	☐	☐

Musculoskeletal

Arthritis	☐	☐

Endocrine

Diabetes	☐	☐
Thyroid disease	☐	☐

Hematologic

Bleeding disorder	☐	☐
Easy bleeding	☐	☐
HIV	☐	☐
HPV	☐	☐

Allergy/Immunologic

Sneezing	☐	☐
Itchy eyes/nose	☐	☐
Itchy throat	☐	
Skin rash/Eczema/Psoriasis	☐	☐

Personal history of cancer	☐	☐

If yes, please explain _____

List all other medical diseases/conditions

Patient Signature: _____