Patient Information Form

MRN#: _____

Last Name: _____First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Marital Status: S M D W
Language: English, Bosnian, French, German, Mandarin, Spanish, Vietnamese, Italian, Decline
Race: African American, American Indian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial, Native American, Declined
Ethnicity: Hispanic or Latino, Non- Hispanic or Latino, Declined
Home Number: _____ Work Number: _____ Mobile Number: _____
Preferred Phone Contact: Home, Work, Mobile Ok to Receive Text Messages: Yes or No
Email Address: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____

Preferred Local Pharmacy: _____ Phone Number: _____
Referring Physician: _____ Primary Care Physician: _____
How did you hear about us: Flyer, Insurance, Radio, Facebook, Patient, Other _____

Guarantor Information (Person bringing in minor)

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

Insurance Information

Primary Insurance: _____ Subscriber/Policy Number: _____
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

Secondary Insurance: _____ Subscriber/Policy Number: _____
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature: _____**Initials:**_____ **Date:** _____
In Lieu of Signature Option, if not available, please type name and initial

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST A COPY OF YOUR INSURANCE CARD AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS-** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $35 may then be added to your account. Cancellations on Ancillary Service will have a higher fee.

- **REFERRALS-** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will personally be responsible for that day's services.

- **CO-PAYMENTS-** By law we MUST collect your carrier designated copay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.

- **FMLA and/or WORKMAN COMP-** There is a $25.00 charge for completion of FMLA or Workman Comp forms.

- **SURGERY DEPOSITS-** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at the time of scheduling. Our scheduling coordinators will work with you to determine the estimated insurance payment and estimated patient responsibility.

- **OUT of NETWORK PLANS-** You will be responsible for any balance your plan indicates as due to their explanation of benefit form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However should they not pay your claim within 45 days, you will be responsible for the full amount. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization of Benefits/Information Release. I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any service furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE-** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENT of MINOR PATIENTS-** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Sound Health Services, P.C. will not be involved with separation or divorce disputes.

- **INSUFFICIENT FUND CHECKS-** A $25.00 fee will be charged to a patient's account for checks returned due to on sufficient funds.

- You are responsible for the timely payment on your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay us, to cover the costs of using a collection agency and an additional 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ Date of Birth: _____

Responsible Party Signature: _____ Intials:_____ Date: _____

In Lieu of Signature Option, if not available, please type name and initial

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I understand that Sound Health Services, P.C. (the "Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or an at of the following telephone numbers

_____.

I authorize Sound to report any test results on any telephone answering devices or service which may answer the telephone number I inserted in the preceding paragraph.

I authorize the Practice to disclose my protected health information to any of the following persons
(state name of person and relationship to you):

_____

_____

_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regards to the Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.
Attn: Privacy Official
1010 Old Des Peres Road
St. Louis, MO 63131

Signature of Patient/Patient's Representative_____Initials:_____ Date:_____
In Lieu of Signature Option, if not available, please type name and initial

Basis of representative's authority to act for patient: _____

Medical History Questionnaire

Patient Name: _____ **Age:** _____ **Date of Birth:** _____ **Male/Female:** _____

Primary Physician: _____ **Pharmacy (Name, Number, & Zip):** _____

Nature of Visit:

- **Chief Complaint** (Reason for today's visit): _____
- **History of Present Illness** (Describe the signs/symptoms that you have, when they started, and how they have changed):
  - **Location** (Where is the problem?): _____
  - **Quality** (Dull, Throbbing, Sharp): _____
  - **Severity** (Mild, Moderate, Severe): _____
  - **Context** (Better, Worse, Chronic): _____
  - **Timing** (Daily, With Activity, At Night): _____
  - **Duration** (How long does it last?): _____
  - **Associated Signs & Symptoms**: _____

Do you currently take ANY medications ☐ Yes ☐ No If Yes, list **Name, Dosage** and **Frequency**:

_____ _____

_____ _____

_____ _____

Drug Allergies: ☐ Yes ☐ No If Yes, list name of **Drug** and **Reaction**: _____

Latex Allergy: ☐ Yes ☐ No _____

- **Past Medical History** (Have you been diagnosed with any of the following? Please check all that apply):

☐ Allergies	☐ Cerebral Palsy	☐ Head Injury	☐ Sleep Apnea
☐ Aneurysm	☐ COPD/Emphysema	☐ Heart Disease	☐ Stroke
☐ Arthritis	☐ Hearing Loss	☐ Hepatitis	☐ Thyroid Disorder
☐ Asthma	☐ Diabetes	☐ Hypertension/High BP	☐ Tinnitus
☐ Autoimmune Disorder	☐ GERD/Reflux	☐ Mental Disorder	☐ Vitamin D Deficiency
☐ Cancer;Type:_____	☐ Kidney Disease	☐ Migraines	
☐ Glaucoma/Cataracts	☐ Lung Disease	☐ Pacemaker	

☐ Other:_____

- **Past Surgical History**:

○ ENT Surgery

☐ Adenoidectomy	☐ Nasal/Sinus
☐ Ear Surgery	☐ Thyroid
☐ Ear Tubes	☐ Tonsillectomy

☐ Other:_____

○ Other Surgery

_____

_____

_____

- **Family Medical History:** (Do any family members have any of the medical problems listed below?)

	Relationship		Relationship
☐ Asthma	_____	☐ Heart Disease	_____
☐ Bleeding Disorder	_____	☐ High Blood Pressure	_____
☐ Cancer	_____	☐ Kidney Disease	_____
☐ Diabetes	_____	☐ Liver Disease	_____
☐ Hearing Loss	_____	☐ Stroke	_____

- **Social History:**

  FLU Shot(Date): _____ **Pneumonia Shot (Date)**: _____

  Do you use Tobacco? (cigarettes,vape,cigars,pipe,snuff/chew) YES☐ NO☐

  If **Yes** please indicate **TYPE** and **Frequency**_____

  If you quit using tobacco please list the year you quit:_____ How many years did you use tobacco?_____

  Do you use alcohol? **YES☐ NO☐** If yes please indicate frequency:_____

  If you quit using alcohol please list the year you quit:_____ How many years did you drink?_____

- Review of Current Symptoms: (Check any of the following that apply to you today)

Constitutional
- ☐ Fever
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Daytime Drowsiness

Eyes
- ☐ Vision Change
- ☐ Eye Drainage
- ☐ Eye Pressure

ENT
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Loss of Smell
- ☐ Tinnitus
- ☐ Nasal Discharge

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Palpitations

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Cough

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Reflux

Musculoskeletal
- ☐ Joint Pain
- ☐ Facial Pain

Neurologic
- ☐ Numbness
- ☐ Headache
- ☐ Migraines

Psychiatric
- ☐ Confusion
- ☐ Anxiety
- ☐ Depression

Endocrine
- ☐ Heat/Cold Intolerance

Hematologic
- ☐ Swell/Lymph
- ☐ Bleeding
- ☐ Abnormal Bruising

Allergic
- ☐ Sneezing
- ☐ Itching
- ☐ Food
- ☐ Seasonal

Skin
- ☐ Rash

PATIENT or RESPONSIBLE PARTY SIGNATURE_____Initials:_____ Date:_____
In Lieu of Signature Option, if not available, please type name and initial

FOR OFFICE USE ONLY

Height: _____ Weight: _____ Temp: _____ BP: _____ Pulse:_____ O2Sat _____

NOTES: _____

_____

_____

_____

_____