BENJAMIN LIESS MD FACS
ENT, ALLERGY, AND AUDIOLOGY, LLC

Patient Intake Form

LAST NAME: **FIRST NAME:** **MI:**		
MAILING ADDRESS:		
PHONE#:	**WORK #**:	**OK to leave message YES / NO**
DATE OF BIRTH:		
SEX:	MARITAL STATUS:	MAIDEN NAME / FORMER NAME:
REFERRAL PRIMARY CARE DOC:	EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE#:
If Patient is a Child: Mothers Name: Fathers Name: AND ADDRESS IF DIFFERENT:		
PATIENTS **LEGAL GUARDIAN**: PHONE #:		
PATIENTS EMAIL ADDRESS: May we contact you via email: yes no		

By providing my email address I understand I will be enrolled in the patient portal account.

Preferred pharmacy_____

Race: White/Asian/African American/Hawaiian-Pacific Islander/American Indian

Ethnicity: Hispanic/Non-Hispanic **Preferred Language**: English/Other_____

INSURANCE & SUBSCRIBER INFORMATION (Please present your card to the receptionist at each visit)

YOU DO NOT NEED TO REPEAT ALL INFO IF WE HAVE A COPY OF YOUR CARD (Subscriber is the Insurance Policy Holder)

PRIMARY INSURANCE:	SECONDARY INSURANCE:
POLICY #:	POLICY #:
INSURANCE ADDRESS:	INSURANCE ADDRESS:
GROUP NUMBER: COPAY	GROUP NUMBER: COPAY
SUBSCRIBER NAME: **ADDRESS IF DIFFERENT:**	**SUBSCRIBER NAME:** **ADDRESS IF DIFFERENT:**
SUBSCRIBER DOB:	**SUBSCRIBER DOB:**
SUBSCRIBER SOCIAL SECURITY #:	SUBSCRIBER SOCIAL SECURITY #:
EFFECTIVE DATE:	EFFECTIVE DATE:

Patient's Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Child ( ) Other_____

ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to myself or the names provided for professional services rendered.

I understand that I am financially responsible for all changes for services including the balance remaining after payment of possible insurance benefits. I authorize release of any medical information to process this claim.

Signed _____ **Date** _____

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Patient Communication Form

Patient's Legal Name: _____
First MI Last

I agree to receive follow up surveys by an automated dialing service and/or an artificial or prerecorded voice, and/or text messages to my telephone number or cell phone number provided during my registration process. Check this box if you do NOT want to receive follow up surveys via cell phone. ( )

Select One:
( ) I do not want any information about my healthcare communicated to family members/caregivers.
( ) I give Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC permission to verbally communicate to family members/caregivers listed below.
Name: _____Name:_____ Name:_____

This authorization will be updated every 12 months. I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC to discuss any other information, including AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone besides myself, I understand that I will need to complete a separate release of information form.

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICIES

I acknowledge that I was notified of the office policies for the office of Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC which may be found on the website www.entmaine.com

ACKNOWLEDGMENT OF HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment
- Follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Benjamin Liess, MD, FACS, ENT, Allergy and Audiology, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient/Parent/Legal Guardian Signature Date Name Printed

Relationship to Patient _____

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Name:

Today's Date:

Reason for today's visit (CC):

Review of Systems (ROS): Do have currently or have you recently had any of these symptoms or conditions?
Please answer Yes or No to every item

1. ALLERGY	Sneezing	Y	N	Post-nasal drip	Y	N	Hay fever	Y	N
2. ENT	Ear pain or itch	Y	N	Ear drainage	Y	N	Throat clearing	Y	N
	Hearing loss	Y	N	Ear noises	Y	N	Throat pain	Y	N
	Dizziness	Y	N	Lightheadedness	Y	N	Throat dryness/itching	Y	N
	Nasal congestion	Y	N	Sinus pressure/pain	Y	N	Hoarseness	Y	N
	Smell problem	Y	N	Snoring, apnea	Y	N			
3. RESPIR	Cough	Y	N	Shortness of breath	Y	N	Coughing blood	Y	N
	Chronic cough	Y	N	Asthma	Y	N			
4. EYES	Vision problem	Y	N	Itchy eyes	Y	N	Migraine	Y	N
5. GI	Heartburn	Y	N	Trouble swallowing	Y	N	Bloody stools	Y	N
	Ulcers	Y	N	Vomiting blood	Y	N	Jaundice	Y	N
6. NEURO	Headache	Y	N	Stroke	Y	N	Seizures	Y	N
7. GENERAL	Frequently tired	Y	N	Weight loss/gain	Y	N	Daytime sleepiness	Y	N
	Night sweats	Y	N	Tuberculosis	Y	N	AIDS	Y	N
	Drug abuse	Y	N	Genetic disease	Y	N	History of cancer	Y	N
8. ENDO	Thyroid trouble	Y	N	Diabetes	Y	N			
9. HEME/LYMPH	Swollen glands	Y	N	Blood transfusion	Y	N	Take aspirin or blood	Y	N
	Abnormal bleeding	Y	N	Anemia	Y	N	thinners?		
10. CARDIAC	Chest pain	Y	N	Irregular heart beat	Y	N	Heart attack	Y	N
	High blood pressure	Y	N	Heart murmur	Y	N			
11. MSK	Joint aches	Y	N	Arthritis	Y	N	Muscle weakness	Y	N
12. GU	Burning urination	Y	N	Bladder problems	Y	N	Prostate problems	Y	N
13. SKIN	Rash	Y	N	Skin disorders	Y	N			
14. PSYCH	Depression	Y	N	Anxiety	Y	N			

I have reviewed elements of all 14 systems with the patient; these are negative except as noted above.

Medications_____

Medication or Latex Allergy

Social history
Employment_____
Marital status_____
How much do you smoke?_____
How much do you drink?_____

Learning style (circle) visual / reading / listening / other

Previous surgeries_____

Medical problems (heart, lung, gastrointestinal, cancer, bleeding/bruising, etc)

Family History of medical problems_____

Signature