ENT Associates of Worcester

Sinus • Hearing • Allergy

Christopher C. Charon, M.D. | Steven Green, MD | Lorna Kay Murdock, APRN

145 Pomfret St. Putnam, CT 06260 Phone (860)928-7330 Fax (860)928-1907 | 246 Southbridge Rd. Charlton, MA 01507 Phone (508)980-7074 Fax (508)434-0821

Last Name:_____ First Name:_____

Mailing Address: _____

City: _____ State: _____ Zip Code:_____

SS#_____-____-_____ Date of Birth:_____ E-Mail_____

Language: _____ Ethnicity: _____ Race: _____

Sex: _____ Marital Status: _____ Occupation:_____

☐ Home Phone: _____ ☐ Cell Phone: _____

Please check preferred number **Do you want us to be able to text you? Yes/No**

Emergency Contact:

Name:_____ Relationship:_____ Phone: _____

Primary Care Physician: _____

Pharmacy: _____ Address:_____

Primary Insurance Card Holder **Self:** ☐

Last Name:_____ First Name:_____

Date of Birth:_____ Phone:_____ Relationship:_____

Address:_____

Guarantor Information (If Minor):

Last Name:_____ First Name: _____

Address:_____ SS#_____-____-_____

City:_____ State: _____ Zip Code: _____ Date of Birth: _____

****Is this appointment Workers Comp or Accident related? YES or NO**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/TO RELEASE INFORMATION: I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS.

_____ _____

Patient Signature (Parent if Minor) **Date:**

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Chief Complaint: _____ **Height:** _____ **Weight:** _____

Past Surgeries - Please check all that apply: None: ☐

_____ Tonsillectomy
_____ Adenoidectomy
_____ Myringotomy
_____ Septoplasty
_____ Tympanoplasty
_____ Sinus Surgery
_____ Appendectomy
_____ Cholecystectomy (Gallbladder)
_____ Cesarean
_____ Hip Surgery - Left / Right
_____ Hernia Repair
_____ Hysterectomy
_____ Knee Surgery - Left / Right
_____ Shoulder Surgery - Left / Right
_____ Pacemaker
_____ Thyroidectomy
_____ Other _____
_____

Past Medical History - Please check all that apply: None: ☐

_____ Heart Attack
_____ Heart Disease
_____ High Cholesterol
_____ High Blood Pressure
_____ Heart Murmur
_____ Pneumonia
_____ Tuberculosis
_____ Asthma
_____ Hepatitis
_____ HIV
_____ Blood Transfusion
_____ AFIB
_____ Acid Reflux
_____ ADD/ADHD
_____ Alzheimer's
_____ Anemia
_____Aneurysm
_____ Autism
_____ Cancer
_____ Clot Factor Deficit
_____ Cleft Palate
_____ COPD
_____ Dementia
_____ Diabetes
_____ Eczema
_____ Emphysema
_____ Glaucoma
_____ Lyme Disease
_____ Migraines
_____ MS
_____ Rheumatic Fever
_____ Stroke / TIA
_____ Substance Abuse
_____ Pacemaker
_____ Other_____
_____

Review of Symptoms: - Please check all that apply: None: ☐

_____ Recent Chest Pain
_____ Shortness of Breath
_____ Easy Bruising
_____ Easy Bleeding
_____ Tremors
_____ Fever
_____ Vomiting
_____ Pain/blood w/ urination
_____ Muscle Cramps
_____ Eyesight Problems
_____ Pregnancy
_____ Palpitations
_____ Wheezing
_____ Fatigue

Family History:

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF
Heart Attack								
Heart Disease								
Asthma								
COPD								
Emphysema								
Cancer								

If the patient is a dependent, with whom do they live? _____

Social History:

Do you smoke? _____ If yes, how many packs per day? _____ For how many years? _____
Did you smoke previously? _____ When did you quit?_____ Chewing tobacco? _____
Alcohol use? YES or NO Is yes, how much per week? Beers: _____ Wine: _____ Hard Liquor _____

Medications & Allergies

Name: _____ **D.O.B** _____

Medications:

Please list name of Medications/Vitamins/Supplements None: ☐

If you have a list of medications, please provide it to the front desk

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

Please list **medication** allergies & your reactions **None:** ☐

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

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CONFIDENTIAL COMMUNICATION REQUEST

Patient Name: _____

Patient Date of Birth:_____

As required by the Health insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through Confidential channels.

Would you like to give our office permission to speak with anyone other than yourself (such as a family member, friend, or facility) regarding your medical information? **YES **or** **NO**

IF YES, PLEASE LIST BELOW:

NAME:_____

RELATIONSHIP:_____

TELEPHONE #:_____

Signature:_____

Print Name:_____

Today's Date:_____

If not signed by patient, please indicate relationship to patient:_____

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REVISED/UPDATED Notice of Privacy Practices Acknowledgement
Full notice available upon request at Front Desk

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 and 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 understand that I may get the complete *Notice of Information Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Information Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Information 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.

Revised Notice:

- *Release authorizations*: Certain disclosures and uses of protected information will require my authorization. They include: 1. Psychotherapy notes. (The notes of a mental health professional that are separate from the record.) 2. Any information the office will use for marketing. 3. Any sale of the office's patient information.
- *Restricting information releases*: A patient who pays for a service in full and out of pocket can request that our office not disclose any information about that service to an insurance company. This request must be in writing specifically requesting what information the patient wants to restrict and what insurance company is not to receive it.
- *Breach notification*: This office will notify me in writing if or when a breach in my protected information occurs.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____