Advantage
ENT & Audiology

Today's Date _____ Please complete ALL sections in BLACK ink. If not applicable, enter N/A.

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Cellphone _____ Can we text? ☐ Yes ☐ No

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Email _____ May we communicate via email? ☐ Yes ☐ No

Work Phone _____ Employer _____

Race _____ Ethnicity _____ Language _____ ☐ Refuse to Answer

EMERGENCY CONTACT

Name _____ Phone _____ Relationship to Patient _____

PHARMACY AND PHYSICIAN INFORMATION

Pharmacy Name _____ City/Cross Streets _____

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____

INSURANCE INFORMATION

Is this a work-related injury/illness? ☐ Yes ☐ No Is this a car accident-related injury/illness? ☐ Yes ☐ No

Complete if the answer above is yes. Claim # _____ Date of Accident/Injury _____

Do you have Medicare due to a disability? (Not age-related) ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Name _____ ID # _____ Group # _____

Specialist Co-pay $ _____ Policyholder's Name _____

(If the patient is NOT the policyholder, please complete the section below.)

Policyholder's Address _____ Phone _____

Policyholder's Social Security # _____ Policyholder's Employer _____

Policyholder's Marital Status _____ Policyholder's Date of Birth _____

Patient's Relationship to Policyholder _____

SECONDARY INSURANCE

Insurance Name _____ ID # _____ Group # _____

Specialist Co-pay $ _____ Policyholder's Name _____

(If the patient is NOT the policyholder, please complete the section below.)

Policyholder's Address _____ Phone _____

Policyholder's Social Security # _____ Policyholder's Employer _____

Policyholder's Marital Status _____ Policyholder's Date of Birth _____

Patient's Relationship to Policyholder _____

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500 W. 144th Avenue, Suite 100, Westminster, CO 80023
3555 Lutheran Parkway, Suite 160, Wheat Ridge, CO 80033
Physicians: 303.431.8881 · Audiology: 303.255.5680 · Fax: 855.324.5322 · www.AdvantageENT.com

Print Patient Name _____ Date of Birth _____

ALL FOUR SECTIONS BELOW MUST BE SIGNED FOR THE PATIENT TO BE SEEN IN OUR OFFICE.

AUTHORIZATION TO PROCESS CLAIMS

I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.

Signature of Patient or Guardian _____ Date _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and acknowledge the financial policies of the office. This policy includes a $50.00 fee for failing to cancel an appointment with a 24-hour notice. I also understand it is my responsibility to update insurance information with the office and to have a current referral from my primary care office and insurance authorization if required by my plan.

Signature of Patient or Guardian _____ Date _____

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices, including marketing contact information. (A copy is available in the office upon request.) We will text appointment reminders to a cellphone if one is provided.

Signature of Patient or Guardian _____ Date _____

Is there anyone we may talk to about medical issues? If yes, enter the info below. ☐ Yes ☐ No

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Can we leave a voicemail regarding medical issues? ☐ Yes ☐ No Phone # _____

Can we communicate via text message? ☐ Yes ☐ No Phone # _____

ELECTRONIC PRESCRIPTION ACCESS

I acknowledge that the office may use an electronic system to look at and prescribe medications.

Signature of Patient or Guardian _____ Date _____

Welcome to our office. Please provide answers to the following questions so that we may better care for you.

Patient Name _____ DOB _____ Today's Date _____

Is there someone designated to make medical decisions in place of the patient? ☐ Yes ☐ No

If Yes, Name _____ Phone # _____

Reason for Today's Visit _____

MEDICATIONS *** Include all reasons for your medications.

Do you take any prescription medications or supplements? ☐ Yes ☐ No

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

Have you had a flu vaccine since last September? ☐ Yes ☐ No If yes, when? _____

If 60+: Date of most recent pneumonia vaccine _____ Any falls in the past year? ☐ Yes ☐ No

MEDICAL HISTORY (diabetes, heart disease, high cholesterol, asthma, allergies, cancer history, etc.)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

ALLERGIES

Do you have an allergy to latex? ☐ Yes ☐ No

Do you have a seafood or iodine allergy? ☐ Yes ☐ No

Do you have an allergy to any medications? ☐ Yes ☐ No

If so, please list.

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

SURGICAL HISTORY (List any surgeries you have had. PLEASE, include right or left.)

1 _____ 3 _____

2 _____ 4 _____

Have you ever had problems with general anesthesia? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

HOSPITALIZATIONS (where, when, what were you seen for?)

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

FAMILY HISTORY (CIRCLE what applies and list who in your family had the issue.)

_____ Hearing Loss _____ Heart Disease _____ Anesthesia Problems

_____ Diabetes _____ Cancer (If yes, what type?) _____

Have you used recreational drugs of ANY type in the past 12 months? _____ What kind? _____

When? _____

CIRCLE APPROPRIATE ANSWERS BELOW

Are you a... ☐ Current smoker ☐ Nonsmoker ☐ Former smoker

Additional Info for a Current Smoker

1. How often do you smoke cigarettes? ☐ Every day ☐ Some days but not every day
2. How many cigarettes a day do you smoke? ☐ 5 or less ☐ 6–10 ☐ 11–20 ☐ 21–30 ☐ 31 or more
3. Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Additional Info for a Former Smoker

☐ Light smoker (1–9 cigs/day) ☐ Moderate smoker (10–19 cigs/day) ☐ Heavy smoker (20–39 cigs/day)

Alcohol Use

1. How often did you have a drink containing alcohol in the last year?
   ☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week
2. On a typical day when you are drinking, how many drinks do you have?
   ☐ 1–2 drinks ☐ 3–4 drinks ☐ 5–6 drinks ☐ 7–9 drinks ☐ 10 or more drinks
3. How often do you have 6 or more drinks on one occasion?
   ☐ Never ☐ Less than Monthly ☐ Weekly ☐ Daily (most days)

Review of System

Patient Name _____ DOB _____ Today's Date _____

Do you have any of the following? (Please check ALL that apply to you.)

ENT
- ☐ Ear infection
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Hearing problem
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Sinus infections
- ☐ Nosebleed
- ☐ Change in smell/taste
- ☐ Nasal drainage
- ☐ Nasal obstruction
- ☐ Facial pain
- ☐ Nasal trauma
- ☐ Snoring
- ☐ Voice change
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Chronic cough
- ☐ Neck mass
- ☐ Head and neck cancer
- ☐ Mouth lesions/sores
- ☐ Tonsillitis
- ☐ Shortness of breath

Ophthalmologic
- ☐ Glaucoma
- ☐ Blurred vision

General/Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight gain
- ☐ Recent weight loss

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Palpitations

Respiratory
- ☐ Asthma
- ☐ Wheezing

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea

Skin
- ☐ Eczema
- ☐ Rash

Hematology
- ☐ Easy bleeding
- ☐ Family history of bleeding
- ☐ Swollen glands

Musculoskeletal
- ☐ Joint pain
- ☐ Neck pain

Psychiatric
- ☐ Anxiety
- ☐ Depressed mood

Infectious Diseases
- ☐ HIV
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis

Neurologic
- ☐ Stroke
- ☐ Headache
- ☐ Seizures/epilepsy

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

Patient Signature _____ Date _____

To comply with Federal HIPAA (Health Insurance Portability and Accountability Act) guidelines, Dr. Van Kooten and Dr. Hartemink have implemented the following policy regarding Patient Privacy and Confidentiality. There are posters in the office with ALL the HIPAA guidelines. This sheet serves as a notification of our policy. (A copy of the entire HIPAA law is available at any time.)

PRIVACY NOTICE

Our office holds patient record information confidential. However, we will use this information for the following reasons: TREATMENT, PAYMENT & HEALTH CARE OPERATIONS. We might disclose your information to the following:

- Primary Care Physician or Other Physicians Involved in Your Care
- Diagnostic Facilities
- Hospitals
- Labs
- Insurance Companies
- Billing and Collection Services
- Workers' Compensation

DISCLOSING RECORD INFORMATION

Release of information to any other entity (not listed above) will require a signed request from the patient or guardian. This request must be dated, show whom the information is to be released to, their address and specify what information will be released. These authorizations are good for one time only. Additional requests will require a separate authorization. We will keep a record of any disclosure of your medical records. This information will be available for your review.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

Patients can review and obtain copies of their records. Our office requires a written request:

- In compliance with federal and state laws, our office will have records available within 10 days of the receipt of the request.

MARKETING

This office, on occasion, will mail information to our patients regarding upcoming sales, promotions or information that may be of value to our patients. I acknowledge that I understand that I may receive some of this information and that this office may receive reimbursement for the cost of these mailings from a third party. I also understand that I have the right to opt-out, in writing, at any time and no longer receive these mailings. Appointment and reminder calls/cards are not bound by these policies.

OTHER INFORMATION

If we need to contact you by telephone and leave a message, we will only leave the practice name, the person calling and our phone number. We WILL NOT leave any medical information on an answering machine or with anyone other than the patient or guardian. It will then be your responsibility to return the call.

PATIENT FINANCIAL POLICY

Billing & Payment: Payment is expected at the time of service unless prior arrangements have been made. Co-pays are required at the time of service prior to being seen. We accept cash, Mastercard, Visa, Discover, American Express and checks with a valid driver's license. If you pay in cash, you will receive a receipt. It is your responsibility to know your co-payment.

Insurance: If your insurance coverage requires a referral from your primary care doctor, it is your responsibility to have that sent to our office prior to making an appointment. As a courtesy, we will submit your bill to your insurance company. Your insurance company will send an Explanation of Benefits (EOB) to you as well as to us. If there is any amount owed by you due to co-insurance or deductible, we will send you a statement reflecting that. If the bill is not paid within 90 days of the date of service, the balance will be due and payable by you. Payment for our services is your responsibility. Please call your insurance company if you have any questions or complaints about your coverage.

Non-Insured Patients: Patients with no insurance are asked to pay for their visit at the time of service. The staff will collect the office visit charge before seeing the doctor. If any other services are performed (audio testing, use of the microscope, etc.), those charges will be expected at the time they are done.

Forms: Disability forms, FMLA forms, restrictions forms/question forms sent by your employer and letters to attorneys will be provided after requested pre-payments are received. If you require documentation for your HRA spending account, please request a copy of your bill at the time of service; otherwise, there will be a $25.00 fee assessed if we have to provide it to you later.

Missed Appointments: Missed appointments or failure to call the office 24 hours before a scheduled appointment will result in a $50.00 charge.

We appreciate your assistance and look forward to serving you.