Statesboro ENT Clinic

Thomas M. Crews MD

Patient Registration Form

Patient Information

Date: _________ Last Name: _________________________ First Name: ______________________ MI: _____

DOB: _________________ Age: _______ Gender: _________ Race: __________ SSN: _________________

Mailing Address: ____________________________________ City/State/Zip: ____________________________

Physical Address: ____________________________________ City/State/Zip: ____________________________

Phone (C): _________________ Phone (H): ________________ Email: _________________________________

Employer:____ Employer Phone: _________________________

Primary Care Physician: _______________________________ PCP Phone: _____________________________

Pharmacy: _________________________________ City: __________________ Phone: _________________

Marital Status: _________ Spouse Name: ____________________________ Spouse Phone: ________________

Guardian (if Minor):_______________________________________ Relationship:_________________________

Phone (C) : ______________________ Phone (H): _______________________ Guardian SSN: _______________

Emergency Contact: _____________________________ Phone: ______________ Relationship: _____________

(EMERGENCY CONTACT # MUST BE DIFFERENT THAN THE PATIENT # AND CELL #)

Significant Medical History: ____

____

Allergies: ____

Reason For Visit: ____ Referred By: __________________________

MEDICAL CONTRACT AND RELEASE OF INFORMATION FOR DR. THOMAS M. CREWS/STATESBORO ENT CLINIC, I/we hereby grant you, Dr. Thomas M. Crews/Statesboro ENT Clinic/your agents the right to confirm and verify all information given to you for the purpose of treatment/billing and collecting. I/we are obligated to pay this account in accordance with all regular rate and terms of this office. I authorize the release of any medical information necessary to process this claim. I authorize payment of insurance benefits directly to Dr. Thomas M. Crews/Statesboro ENT Clinic for services rendered. If this account should be turned over to a collection agency/attorney for nonpayment, I/we assume responsibility for the full cost of all collection/legal fees. I/we understand all delinquent accounts will be assessed at 1.5% interest monthly. I/we authorize the release of any medical or credit record necessary to process and collect this claim. I certify all information given is correct.

Patient/Guardian Signature: ____ Date: __________________

Insurance: ____________ Subscriber Name & DOB: _________________________ Medicaid: ___ Medicare: ___

Tricare - Sponsor Name: ______________________ DOB: ____________________ SSN: _________________

EAR, NOSE AND THROAT CHILD QUESTIONAIRE

PLEASE ANSWER COMPLETELY

IF YOU ARE NOT HAVING SORE THOATS, SNORING, NOSEBLEEDS OR EAR INFECTIONS, YOU MAY SKIP THIS PAGE.

SORE THROATS:

HOW MANY **SORE THROATS/INFECTIONS** HAS THE CHILD HAD IN THE PAST YEAR?______________

WHAT ANTIBIOTICS WERE GIVEN?:

AUGMENTIN **OR** AMOXICILLAN **OR** OTHER__________________________

HOW MANY "ROUNDS" OF ANTIBIOTICS WERE GIVEN?____________________________

HOW MANY DAYS OF SCHOOL HAS THE CHILD MISSED DUE TO THIS ILLNESS?:___________________

SNORING:

HOW LONG HAS THE CHILD BEEN **SNORING/MOUTH BREATHING**?:

6 MONTHS **OR** 12 MONTHS OR LONGER

NOSEBLEEDS:

HOW MANY **NOSEBLEEDS** HAS THE CHILD HAD IN THE PAST 3 MONTHS?_________________________

EAR INFECTIONS:

HOW MANY **EAR INFECTIONS** HAS THE CHILD HAD IN THE PAST YEAR?_________________________

PLEASE CIRCLE ANY OF THE FOLLOWING ASSOCIATED WITH THE **EAR INFECTIONS**:

CRYING FEVER PULLING AT EARS

WHAT ANTIBIOTICS WERE GIVEN?

AUGMENTIN **OR** AMOXICILLAN **OR** OTHER__________________________

HOW MANY "ROUNDS" OF ANTIBIOTICS WERE GIVEN?____________________________

HOW MANY DAYS OF SCHOOL HAS THE CHILD MISSED DUE TO THIS ILLNESS?:___________________

HEARING:

HAS THE CHILD FAILED A HEARING TEST? YES **OR** NO

IF SO, HOW MANY?______________

Kids Only!

STATESBORO ENT & HEARING CLINIC
STATESBORO ENT SURGICAL CENTER, P.C.
106 PROCTOR STREET
STATESBORO, GA 30458
(912) 764-8200
1-800-526-0998

PATIENT NAME: ____

NAME OF PARENT/GUARDIAN IF PATIENT IS A MINOR: ______________________________

I have released to you all the insurance information that the patient listed above has. I understand that insurance is filed as a courtesy to me, and I have no other insurance coverage to provide. I will be responsible for any balance that my insurance does not pay and will be willing to set up payment arrangements as needed. I have read and fully understand all the information stated above.

______________________________________ ____________________
PATIENT/LEGAL GUARDIAN SIGNATURE DATE

STATESBORO ENT & HEARING CLINIC
STATESBORO ENT SURGICAL CENTER, P.C.

Patient Consent for Use/Disclosure of Protected Health Information and Procedures/Treatments

IMPORTANT: **Do not sign this form without reading and understanding its contents.**

With my consent, Statesboro ENT Clinic and Statesboro ENT Surgical center may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Statesboro ENT Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Statesboro ENT reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Christa Wells, LPN, Administrator at 106 Proctor Street, Statesboro, Georgia 30458. With my consent, Statesboro ENT clinic or Surgical Center may mail and/or call to my home or other designated location and leave a message on voicemail or with a person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, patient statements, or clinical care, including laboratory results among others, as long as they are marked personal and confidential.

I have the right to request that Statesboro ENT clinic or Surgical Center restrict how it uses or discloses my protected health information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound in this agreement. By signing this form, I am consenting to Statesboro ENT Clinic and Surgical Center's use and disclosure of my protected health information. I may revoke my consent in writing except to the extent that the practice has already made disclosures in relevance upon my prior consent. If I do not sign this consent, Statesboro ENT Clinic or Statesboro ENT Surgical Center may decline to provide treatment to me.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with each Procedure. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

Physical tests, assessments and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures such as needle sticks, shots, injections, intravenous injections (IV's) may have risks that include, but are not limited to, allergic reaction, nerve damage, infection, infiltration (which is fluid leaking into surrounding tissues), blood loss, disfiguring scars, loss of limb function, paralysis or partial paralysis or death. Alternatives to needle sticks include oral, rectal, nasal, or topical medications (each of which may be less effective) or the refusal of treatment, and apart from using modified procedures and/or refusal of treatment, no practical alternatives exist for physical tests and assessments.

Administration of Medications whether orally, rectally, topically or through my eye, ear, or nose may have risks associated including, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist. Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis also may have material risks associated including, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist. The insertion of internal tubes such as bladder catheterizations, nasogastric tubes, and rectal tubes, also may have material risks including, but are not limited to, internal injuries, bleeding,

infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collective devices and/or refusal of treatment, no practical alternatives exist.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

I understand that:

The practice of medicine is not exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedure.

The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and Physicians rendering services to me are independent professionals engaged in the private practice of Medicine (and are not employees or agents of the Hospital).

By signing this form:

I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and I acknowledge that I have been informed in general terms of nature and purpose of the Procedures, the material risks of the Procedures, and the practical alternatives to the Procedures.

Signature of Patient/Legal Guardian: ______________________________

Printed Name of Patient/Legal Guardian: ______________________________

Patient's Name (if Minor) ______________________________

Date Signed: ______________________________

Explained/Witnessed By: ______________________________

CONSENT FOR USAGE OF LIDOCAINE, PRILOCAINE, OR BENZOCAINE DROPS

This document is meant to inform patients in their usage of the drug lidocaine, prilocaine, or benzocaine topical solution in the ear for the purpose of treating "various maladies." The usage of these topical solution medications is voluntary.

Lidocaine, Prilocaine, and Benzocaine are topical anesthetics that are suspended in glycerin for the purpose of topical anesthesia to specific nerves in the ear canal. These medications have been used for decades in the United States with very few side effects and are very well tolerated by human beings. On rare occasions, people may have Lidocaine, Prilocaine, or Benzocaine sensitivities. These may consist of burning, itching, redness, swelling of the ear canal, problems with breathing, headaches, ringing in the ears, dizziness, and lightheadedness. Swelling of the ear canal, lips, tongue, throat and eyes may also rarely occur. On rare instances, a person may have heart palpitations or wheezing. If these or other unexplained side effects occur, cessation of the usage of the ear drops should be immediate, and individuals should call the clinic to speak with Dr. Crews directly. They can also reach Dr. Crews by calling East Georgia Regional Medical Center and ask for Dr. Crews to be paged.

It is our sincerest hope that any and all patients get benefits from the usage of Lidocaine, Prilocaine, or Benzocaine in topical form. Very little of the medications are absorbed through the skin of the ear canal. It should be avoided in individuals with a hole in the ear drum. The drug is typically to be used at night before one retires and a cotton ball is always placed in the external canal to hold the medication in place.

These medication solutions are unapproved individually marketed drugs. They have not been approved through FDA trials in the usage of topical medication for the ear canal, but they are approved generic medications which have been on the market for over 70 years with mild side effects. The typical usage of Lidocaine/Prilocaine is topical and is gentle enough to be used directly on people's skin with relatively few side effects. Lidocaine have been used topically, orally, and on/in almost any part of the human body. It is also over the counter in a 5% gel form. Topical usage in the ear canal with an intact eardrum is extremely unlikely to cause any side effects, but if side effects are encountered, immediate cessation of the drops is recommended and discussion with your prescribing physician is highly recommended.

The FDA has not completed or approved evaluations of Otic Lidocaine/Prilocaine or Benzocaine for safety or effectivity. It is not intended to diagnose, treat, or cure any disease.

Please sign below to acknowledge that you have read and understand this consent for usage of Lidocaine, Prilocaine, and Benzocaine.

Patient/Guardian Signature: ______________________________ Date: ____________

SYMPTOMS OF DYSAUTONOMIA

[Please circle any symptoms that pertain to you]

Name: ___________________________

BLURRED VISION / EXCESSIVE TEARING / DRY EYES / EYE PAIN / ITCHY EYES

CHRONIC NASAL CONGESTION / DRY NOSE / RUNNY NOSE / SNEEZING

ALLERGIC RHINITIS / NASAL POLYPS / NOSEBLEEDS / RECCURENT SORE THROATS

THROAT DRAINAGE / DRY MOUTH / EXCESSIVE SALIVA / DIFFICULTY SWALLOWING

RECURRENT HOARSE VOICE (DYSPHONIA) / LUMP IN THROAT (GLOBUS HYSTERICUS)

RECURRENT PAIN IN EAR / TINNITIS / TMJ PAIN / TOOTH PAIN / REFLUX

GASTRITIS / HICCUPS / BLOATING / NAUSEA / VOMITING / CHRONIC ABDOMINAL PAIN

GALLBLADDER PAIN OR REMOVED/ PANCREATITIS PAIN / GASTROPARESIS

ULCERATIVE COLITIS / STOMACH GROWLING (FEELING OF CONSTANT HUNGER)

IRRITABLE BOWEL COMPLAINTS / BOWEL SPASM / DIARRHEA / CONSTIPATION

OVERACTIVE BLADDER (FREQUENCY) / URGENCY / BED WETTING

NIGHT TIME URINATION / SLOW OR PROLONGED URINATION / PAINFUL URINATION

CHRONIC PELVIC PAIN / PAINFUL INTERCOURSE / ENDOMETREOSIS / HEAVY FLOW

PROLONGED PERIODS / PAINFUL PERIODS / EXCESSIVE DRYNESS/ DECREASED LIBIDO

ASTHMA / COPD / CHRONIC COUGH / SHORTNESS OF BREATH / SLEEP APNEA

SNORING / PROBLEMS SLEEPING / FREQUENT AWAKENINGS

ATRIAL FIBRILATION / IRREGULAR HEARTBEAT / HEART ATTACK / HYPERTENSION

STROKE / HEART FAILURE / KIDNEY FAILURE / ANGINA / TIAS

DIABETES / ELEVATED A1C / ELEVATED CHOLESTEROL / CREATININE

CHRONIC FATIGUE / FIBROMYALGIA (BODY ACHES) / SCIATICA (LOW BACK PAIN)

MIGRAINES / CHRONIC HEADACHES / FACIAL PAIN / BRAIN FOG / SCALP PAIN

DEPRESSION / CHRONIC ANXIETY / PANIC ATTACKS / PTSD / BIPOLAR DISORDER

TOURETTES / AUTISM SPECTRUM / UNSTEADY WALKING / OSTEOPOROSIS

RESTLESS LEG / LEG CRAMPS / BLOOD CLOTS IN LEGS / PERIPHERAL NEUOPATHY

REFLEX SYMPATHETIC DYSTROPHY (RSD) / DIABETIC NEUOPATHY / DYSAUTONOMIA

ALTITUDE SICKNESS / MOTION SICKNESS / OBSESSIVE COMPULSIVE THINKING / ADHD

AUTISM / APRXIA (SPEECH IMPAIRMENT) / HAND TREMORS / PARKINSONS

DEMENTIA /ALZHEIMERS / CEREBRAL PALSY / SEIZURES / POTS

ORTHOSTATIC HYPOTENSION / SYNCOPE (PASSING OUT) / COLD HANDS AND FEET

RAYNAUDS / SCLERODERM / PERIPHERAL VASCULAR DISEASE

EXCESSIVE SWEATING / PSORIASIS / ACNE / ECZEMA / ITCHY RED RASH

HOT FLASHES / FACIAL BLUSHING / ROSACEA / ALOPECIA AREATA

FOCAL DYSTONIA / NECK / TORSO / HANDS / LEGS / FEET