J. Scott Robertson, M.D.

MEDICAL INFORMATION FORM

Name:_____ **DOB:**_____ **Today's date:**_____

How did you hear about us: _____ **Pharmacy & Location:**_____

Reason for Visit:_____

Length of time you have had this problem:_____

Medications you have taken for this problem?_____

Current Medications and Dosage: (All medications including over the counter and vitamins)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies and Reactions:_____

Medical History: (please choose yes or no for any medical problems you have had)

Heart Attack	Y N	Acid Reflux	Y N	Anemia	Y N
Heart Disease	Y N	Hiatal Hernia	Y N	Hemophilia	Y N
Irregular Rhythm	Y N	Diabetes	Y N	Bleeding Issues	Y N
Vascular Disease	Y N	Tuberculosis	Y N	Blood Clot	Y N
High Blood Pressure	Y N	Thyroid Disease	Y N	Transfusions	Y N
Stroke	Y N	Kidney Disease	Y N	Arthritis	Y N
Emphysema/COPD	Y N	HIV (AIDS)	Y N	Hepatitis	Y N
Asthma	Y N	Immune Deficiency	Y N	Cancer	Y N

Other Medical Problems:_____

Surgical History: List previous surgical procedures & date performed:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL INFORMATION FORM (CONTINUED)

Family History: (please choose yes or no)

Hearing Loss	Y N	Allergies/Sinus Problems	Y N
Bleeding Problems	Y N	Anesthesia Problems	Y N

Social History:

Do you/have you ever smoked? _____ How many years?_____

Any other forms of tobacco? _____

Do you drink alcohol?_____ Drinks per week? _____

Do you use any recreational drugs? _____

Height: _____ **Weight:** _____

Review of Systems: Do you have or have you recently had any of the following? (choose Y or N)

Fatigue	Y N	Change in vision	Y N	Voice change	Y N
Fever	Y N	Double vision	Y N	Enlarged lymph nodes	Y N
Loss of appetite	Y N	Cough	Y N	Chest Pain	Y N
Night sweats	Y N	Nosebleeds	Y N	Shortness of breath	Y N
Weight loss	Y N	Decrease smell	Y N	Nausea/Vomiting	Y N
Seasonal allergies	Y N	Nasal congestion	Y N	Heartburn or reflux	Y N
Facial pressure	Y N	Postnasal drip	Y N	Easy bleeding	Y N
Headache	Y N	Runny nose	Y N	Rash or hives	Y N
Dizziness	Y N	Snoring	Y N	Numbness/tingling	Y N
Ear drainage	Y N	Mouth sores	Y N	Seizures	Y N
Ear pain	Y N	Problems swallowing	Y N	Migraine	Y N
Ear fullness	Y N	Painful swallowing	Y N	Depression	Y N
Hearing loss	Y N	Throat Pain	Y N		
Ear ringing	Y N				

Are you on any blood thinners (e.g. aspirin, Vitamin E, Fish Oil)? _____

Do you have Sleep Apnea? Y N **Have you had a sleep study?** Y N

If YES date of sleep study: _____ **Location:** _____

Physician & Nurses notes

Patient Registration

J. Scott Robertson, M.D., P.C
Scott Robertson, M.D.
Ryan Marshall, M.D.

Today's Date: _____ Referring Doctor: _____

Social Security Number: _____

Last Name: _____ First Name: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Sex: Male or Female Date of Birth: _____ Race: _____

Ethnicity (please circle one) Caucasian Hispanic Not Hispanic Prefer Not to Answer

Marital Status (please circle one) Single Married Divorced Widowed

Primary Language: _____

Home Number: _____

Work Number: _____ Employer Name: _____

Cell Number: _____

Do you authorize this office to call with appointment reminders? Yes or No Text? Yes or No

Cell Phone Carrier: _____ (please provide to receive appointment reminders)

Email Address: _____

Emergency Contact Name: _____ Phone Number: _____

Insurance Information

Primary Insurance Company: _____ Contract ID: _____

Primary Subscriber Name: _____ Date of Birth: _____

Secondary Insurance Company: _____ Contract ID: _____

Secondary Subscriber Name: _____ Date of Birth: _____

Person responsible for receiving all financial statements:

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to pay directly to physician. I understand I am financially responsible for any balance. I also authorize J. Scott Robertson, M.D., P.C or my insurance company to release any information required to process my claim.

Patient or Guardian Signature: _____ Date: _____

J. Scott Robertson, M.D., P.C.

Patient Name: _____ **DOB:** _____

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding protected health information. I understand this information can and will be used for payment, treatment and for health care operations. I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses of my health information. I understand that the office of J. Scott Robertson, M.D., P.C. has the right to change its Notice of Privacy Practices and I may contact the office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that the office of J. Scott Robertson, M.D., P.C., restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that the office of J. Scott Robertson, M.D., P.C., is not required to agree to my requested restrictions, but if the practice does then the practice is bound to abide by such restrictions. **I understand this form is required to be signed on an annual basis however I am waving that right and the below signature is to remain active until I leave the practice. I understand that at any time I may request an updated copy of HIPAA and my signature will be required at that time.**

Patient or Guardian Signature: _____ Date: _____

Financial Acknowledgements

I acknowledge that certain procedures my physician recommends may be applicable towards my deductible or I may be billed a certain percentage based on my individual contract with my insurance carrier. This may result in a charge greater than my copay and I accept financial responsibility and agree to make payments in a timely manner. I understand the billing department is available to go over any questions before any recommended procedure and I further understand that the office observes the following financial policies:

-A $50 (24 hour) cancellation fee

-A $250 surgery deposit will be required at time of scheduling surgery and if I cancel 14 days prior to my surgery the deposit is nonrefundable.

- A $25.00 forms fee will be charged for any forms filled out by the office.

Patient or Guardian Signature: _____ Date: _____

Patient Contact Information

J. Scott Robertson, M.D., P.C. or any staff member has my permission to discuss my account and medical conditions which may included symptoms, treatment, diagnosis, test results, medications, or any other protected health information with my emergency contact and the following persons in order to facilitate and coordinate my care, treatment and payment.

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Patient or Guardian Signature: _____ Date: _____