601 E Dixie Ave., Plaza 901, Leesburg, FL 34748
1501 US 441 N, Suite 1402, The Villages, FL 32159
1819 Salk Ave, Tavares, FL 32778

DATE: ____________________

NAME: ____ DATE OF BIRTH: ______________________

ADDRESS (Local Mailing Address): ____

____

ADDRESS (Permanent - If Not Resident): ____

Home Phone: ______________________________ Cell Phone: ______________________________

Work Phone: ______________________________ Email: ______________________________

Social Security Number: ____________________________ Marital Status: ____________________ Sex: M or F

Race: ____________________ Preferred Language: ____________________ Ethnicity: ____________________

Height: ______________ Weight: ______________

Employment/Student Status: __________________________ Employer: ______________________________

Local Pharmacy: ________________________ Pharmacy Address/Phone: ______________________________

Emergency Contact: ______________________ Phone: ____________________ Relationship: ______________

Primary Care Physician: ____

Which physician requested for us to see you? ____

Spouse Name: ____________________________ Spouse Employer Phone No: ________________________

Spouse Social Security Number: ____

Spouse Employer: ____________________________________ Spouse Date of Birth: ____________________

Name of Health Insurance: ____

If patient is a MINOR:

Mother's Name: ________________________ Address: ____________________________________

Social Security Number: __________________________________ Mother's Date of Birth: ____________________

Employer: ____ Employer Phone: ________________________

Father's Name: ________________________ Address: ____________________________________

Social Security Number: __________________________________ Father's Date of Birth: ____________________

Employer: ____ Employer Phone: ________________________

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AUTHORIZATION CONSENT

I, the below named patient, parent, guardian or authorized representative of patient, hereby consent to such medical care encompassing the routine diagnostic procedures and medical treatment by my attending physician.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT'S AND AUTHORIZATION TO RELEASE INFORMATION.

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed any customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient's Name (print): ____ Date: ______________________

Signature of Patient or Legal Guardian: ____

Patient's Name: ____ **Date:** ____________________

SOCIAL HISTORY

DO YOU USE TOBACCO NOW? ___ YES ___ NO TYPE & DAILY AMOUNT: ______________________

HOW LONG? _____________________

IN THE PAST? ___ YES ___ NO TYPE & DAILY AMOUNT: ______________________

HOW LONG? _____________________ IF STOPPED, WHEN? _____________________

DO YOU USE ALCOHOLIC BEVERAGES? ___ YES ___ NO IN THE PAST? ___ YES ___ NO

TYPE: ___________________ WEEKLY AMOUNT: _______________ HOW LONG? ___________

REVIEW OF SYMPTOMS:

Which of the following symptoms do you presently have?

______ FEVER

______ WEIGHT GAIN

______ WEIGHT LOSS

______ FATIGUE

______ LUMPS IN NECK

______ HEARING LOSS

______ DIZZINESS

______ EAR PAIN

______ DIFFICULTY SWALLOWING

______ HOARSENESS

______ NASAL CONGESTION

______ RUNNY NOSE

______ SORE THROAT

______ SNEEZING

______ FACIAL PRESSURE

______ HEADACHE

DATE OF LAST MENSTRUAL PERIOD (IF APPLICABLE):

____

______ WATERY EYES

______ ITCHY EYES

______ HEARTBURN

______ ACID REFLUX

______ STOMACH PAIN

______ PALPITATIONS

______ SHORTNESS OF BREATH

______ WHEEZING

______ COUGH

______ BLOOD TRANSFUSION

______ BRUISING

______ SENSITIVITY TO HEAT OR COLD

______ SKIN LESION

______ SKIN RASH

______ WEAKNESS IN ARMS OR LEGS

______ NUMBNESS IN ARMS OR LEGS

______ SNORING

______ DAYTIME SLEEPINESS

______ WAKE UP CHOKING OR GASPING

Today's Date:	
Patient Name:	Date of Birth:
Pharmacy:	Pharmacy Phone #:
LIST MEDICATIONS WITH DOSAGE YOU ARE PRESENTLY TAKING (INCLUDING ASPIRIN, ORAL CONTRACEPTIVES & VITAMIN SUPPLEMENTS)	

Patient's Name: ____ **Date:** ________________________

PAST MEDICAL HISTORY - Which of the following conditions have you had?

______ ARTHRITIS
______ ASTHMA
______ ATRIAL FIBRILLATION
______ GERD
______ DIABETES
______ EMPHYSEMA
______ HEART ATTACK
______ GLAUCOMA
______ GOITER
______ HIGH BLOOD PRESSURE
______ HEART DISEASE
______ HEPATITIS
______ HYPERTHYROIDISM
______ HIGH CHOLESTEROL
______ HIV
______ PNEUMONIA
______ HYPOTHYROIDISM
______ KIDNEY DISEASE
______ TUBERCULOSIS
______ SLEEP APNEA
______ STROKE
______ NEUROMUSCULAR
______ COPD
______ NEUROLOGICAL
______ CANCER (Type): ____________________________

ALLERGIES TO MEDICATIONS: ____
____
____

PREVIOUS OPERATIONS: _______ **YES?** _______ **NO?** **If yes, please check or list, giving dates:**

______ CANCER SURGERY OF HEAD / NECK
______ NASAL / NOSE SURGERY
______ SINUS SURGERY
______ SKIN CANCER SURGERY
______ FACIAL PLASTIC / COSMETIC SURGERY
______ EAR SURGERY (Type): _________________
______ THYROID / PARATHYROID SURGERY
______ HEART SURGERY (Type): _______________
______ **OTHER SURGERIES:** ____
____

FAMILY HISTORY Living? YES / NO	**AGES OR AGES @ DEATH**	**PRESENT HEALTH OR CAUSE OF DEATH**
FATHER _____ YES _____ NO	___________________	___________________
MOTHER _____ YES _____ NO	___________________	___________________
SPOUSE _____ YES _____ NO	___________________	___________________
SIBLINGS _____ YES _____ NO	___________________	___________________
CHILDREN _____ YES _____ NO	___________________	___________________

Please mark illnesses which have occurred in any of your blood relatives:

______ Abnormal Bleeding
______ Diabetes
______ Heart Disease
______ Stroke
______ Cancer
______ High Blood Pressure
______ Kidney Disease

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I acknowledge and agree that Lake Ear, Nose, Throat & Facial Plastic Surgery Associates may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

____
Print name, relationship, and phone number

____
Print name, relationship, and phone number

____
Print name, relationship, and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

____ Date: ____________________
Signature of Patient or Authorized Representative

HIPAA PRIVACY NOTICE

I have received and/or have seen and acknowledge the HIPAA PRIVACY NOTICE of Milstead, Vaught & Madonna, MD, PA. This Privacy Notice is for Judith C. Milstead, MD, S. Dwight Vaught, MD, Dino Madonna, MD, Michael Freedman, DO, Jenniffer Ferguson, PA-C and Christine Halvorsen, PA-C.

Patient's Name (print): ____ Date: ____________________

Signature of Patient or Authorized Representative: ____