

**PLEASE LIST THREE CONTACT NUMBERS!**

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: F M

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Separated  Student Status: PT FT

**Home Phone** \_\_\_\_\_ **Day Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

Employer: \_\_\_\_\_ occupation? \_\_\_\_\_  Retired?

Spouse/Parent/Legal Guardian \_\_\_\_\_

**Primary Medical Insurance- Information needed in order to File Insurance**

- Aetna
- BCBS
- BCBS Pathway X
- Cigna
- Medicare
- Medicaid
- Taylor Benefit
- Other \_\_\_\_\_

Policy holder name: \_\_\_\_\_ d.o.b. \_\_\_\_\_

2<sup>nd</sup> ins \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Referring by Physician** \_\_\_\_\_ **Internet** \_\_\_ **Face Book** \_\_\_ **Website** \_\_\_ **Friend** \_\_\_ **TV** \_\_\_

**Family physician:** \_\_\_\_\_

To allow for more efficient scheduling we require a 24 hour cancellation notice for OFFICE VISITS. In the event this is not met, a \$50.00 fee will be charged to your account. No show without a 24 hour notice -\$100 charge for PROCEDURES & TEST. (ONE) week cancellation notice for all SURGERIES. In the event this is not met, you will be charged a (\$200.00) fee.

\_\_\_\_\_  
**Initials**

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I hereby authorize Dr. Berger to obtain records from other sources as may be required in the treatment of this patient or to release information concerning this patient's treatment to other professionals. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received a copy of Dr. Berger's privacy practice.**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent or Responsible Party**

JOSEPH BERGER, M.D. and SOUTH GA AUDIOLOGY & HEARING CENTER

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Chief complaint: \_\_\_\_\_

Duration (how long) ago did problem start: \_\_\_\_\_

Severity (mild, moderate, and severe): \_\_\_\_\_ Timing (constant, off & on, etc.) \_\_\_\_\_

Aggravating factors (things that make the problem worse): \_\_\_\_\_

Alleviating factors (things that help relieve \_\_\_\_\_

Associated symptoms (other symptoms that seem related to chief complaint): \_\_\_\_\_

Have you been treated by a Physician for this problem? \_\_\_\_no \_\_\_\_yes If so, what treatment was given?

Medical History (*this information pertains to the patient only*)

Medication Allergies? \_\_\_\_no \_\_\_\_yes - please list \_\_\_\_\_

Food or Latex Allergy? \_\_\_\_no \_\_\_\_yes - please list \_\_\_\_\_

List previous EAR, NOSE OR THROAT operations, give date of procedure or age when performed

\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_

Have you ever had any problems associated with receiving general anesthesia? \_\_\_\_no \_\_\_\_yes

If yes, provide details \_\_\_\_\_

*Females only:* If currently pregnant # weeks \_\_\_\_\_ Breast feeding? \_\_\_\_no \_\_\_\_yes

Social History: \*\*\* (*this information pertains to the patient only*)

Tobacco use:  Never  Dip/chew  cigarettes  pipe  cigars  
how much? \_\_\_\_\_ how often? \_\_\_\_\_ how long? \_\_\_\_\_

If you have stopped, when did you stop? \_\_\_\_\_

Alcohol use:  No  Yes - List type \_\_\_\_\_, amount \_\_\_\_\_ & frequency \_\_\_\_\_

Drug use:  No  Yes - List type \_\_\_\_\_, amount \_\_\_\_\_ & frequency \_\_\_\_\_

Infant / Toddler - currently in daycare setting? \_\_\_\_no \_\_\_\_yes

Misc: Have you ever tested positive for Hepatitis or HIV? \_\_\_\_no \_\_\_\_yes

If yes, explain \_\_\_\_\_

Would you accept blood transfusion in the event of a life threatening situation? \_\_\_\_no \_\_\_\_yes

Family History (*this information pertains to (family members)-mother-father-sister-brother*)

Hearing loss Heart problems Cancer Diabetes Thyroid Disease Bleeding disorder Sleep Apnea  
Sinus / Allergy Problems Anesthesia problems Other (specify) \_\_\_\_\_

(OVER)

**REVIEW OF SYSTEMS \*\*\* (this information pertains to patient only; check all that apply):**

**EARS:**    Hearing Loss    Tinnitus (noise in ears)    Hearing comes and goes    Balance problems  
          Dizzy (Vertigo)    Pain    Drainage    Recurrent infection  
          Hole in ear drum    Fluid in ears    Wax Impaction    Exposure to Loud Noise  
          Hearing Aids    Other \_\_\_\_\_

**NOSE:**    Difficulty breathing    Stiffness    Clear nasal drainage    Discolored nasal drainage  
          Recurrent infection    Post Nasal Drip    Sneezing    Snoring    Noisy breathing  
          Change in smell    Bleeding    Injuries    Deformity    Deviated septum    Polyps  
                          Sense of smell    Other \_\_\_\_\_

**THROAT:** Pain    Difficulty Swallowing    Painful Swallowing    Voice changes / hoarseness  
          Chronic Cough    Sensation of lump in throat    Frequent throat clearing  
          Choking or strangling sensation    Recurrent Infection    Enlarged Tonsils  
          Tonsillitis    Other \_\_\_\_\_

**MOUTH:** Mouth breathing    Bad breath/ Foul Odor    Bad taste    Oral lesion    Sleep Apnea  
          Tongue Tied    Other \_\_\_\_\_

**NECK:**    Mass/lump    Swollen glands    Pain    Injuries    Thyroid nodules  
Other \_\_\_\_\_

**HEAD & FACE:**    Skin Lesions    Persistent headaches    Facial pain/pressure    Injuries  
                          Other \_\_\_\_\_

**GENERAL:** *If you currently have or have had medical problems in the following areas please check and provide explanation*

- Diabetes \_\_\_\_\_     High blood pressure \_\_\_\_\_
- Cancer \_\_\_\_\_     Hypo/Hyperthyroidism \_\_\_\_\_
- Eyes \_\_\_\_\_
- Heart/Vascular \_\_\_\_\_
- Breathing/Respiratory \_\_\_\_\_
- Stomach/Intestinal \_\_\_\_\_
- Urinary/Kidneys \_\_\_\_\_
- Muscles / Bones \_\_\_\_\_
- Skin \_\_\_\_\_
- Neurological \_\_\_\_\_
- Mental Health/Psychiatric \_\_\_\_\_
- Blood/Immune System \_\_\_\_\_
- Endocrine/Lymph System \_\_\_\_\_
- Other \_\_\_\_\_

**NAME OF PHARMACY AND LOCATION:** \_\_\_\_\_

Is there anything else about your medical history or current condition that might be helpful for the doctor to know? (please specify)

\_\_\_\_\_

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PHYSICIAN SIGNATURE:** \_\_\_\_\_

# MEDICATION LIST

JOSEPH H. BERGER M.D.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

	<b>List medications, (including over-the-counter) and Nose Sprays</b>	<b>Strength (mg) and Frequency</b>
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

**JOSEPH BERGER, M.D.**  
**SOUTH GA AUDIOLOGY & HEARING CENTER**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Joseph Berger, M.D., and South Ga Audiology & Hearing Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Joseph Berger, M.D.'s Notice of Privacy Practices provides 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. Joseph Berger, M.D., and South Ga Audiology & Hearing Center reserve the right to revise its Notice of Privacy Practices at anytime.

With this consent, Joseph Berger, M.D., and South Ga Audiology & Hearing Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I authorize the release of any financial or Medical information to the following individuals (listed below).

\_\_\_\_\_  
\_\_\_\_\_

**The Federal Trade Commission (FTC) has released a new rule to protect consumers from Identity Theft, "Red Flag Rule". Dr. Berger will now require a copy of your Drivers License or state issued form of identification with picture. Also, proof of Insurance.**

I fully understand and accept the terms in this consent.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_\_