NORTHERN VIRGINIA ENT ASSOCIATES

UNDER 18 YEARS OF AGE PATIENT MUST BE ACCOMPANIED BY A PARENT

PATIENT INFORMATION DATE:____/_____/_____

Name:____ Sex M F Birthdate:_____/_____/_____
Last First MI

Street Address:____

City, State, Zip:____

Home Phone:_________________ Cell Phone:______________ Work Phone: ______________________

Emergency Contact: ___________________________ Phone: _______________ Relation: __________________

Email Address: ____

INSURANCE INFORMATION

Policyholders Name:__________________________ Birthdate:_____/_____/_____

Home Address, if different from above:____

City, State, Zip:____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge receiving on
___________________________, a copy of NOVA ENT Associates Notice of privacy practices.
(Print date)

Patient Signature: ____

Patient Responsibility

All appointments must be scheduled in advance. If you need to cancel or reschedule an appointment, please call 24 business hours before your scheduled appointment. There will be a $50 charge to your account for all missed or cancelled appointments that are not cancelled at least 24 business hours in advance.

Patient/Guardian Signature:____

NORTHERN VIRGINIA ENT ASSOCIATES

PATIENT AUTHORIZATION

I, ________________________________ hereby authorize Northern Virginia ENT Associates to apply for benefits on my behalf for covered services rendered and request payment by insurance company be made directly to Northern Virginia ENT Associates. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named agent. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. NOTE: IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT'S RESPONSIBILITY. I also agree to be responsible for charges incurred and additional costs associated with enforcing this agreement, including collection costs and reasonable attorney's fees. I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC, or any of its affiliates.

____________________ ____

Date **Signature of Subscriber or Patient**

Authorization to Release Patient Information

I, _______________________________________, hereby authorize the physicians and staff of Nova ENT, to release any and all information pertaining to my health care, test results procedures, billing and/or accounting information to the following person(s) or agencies:

Name___________________________ Phone #________________ Relation: ____________________

I further authorize the physicians and their staff to contact me for appointments/ results, etc in one or more of the following ways:

May leave a message during business hours at:

_____Home ______Work _____Ans. Machine at home _____Voicemail at work

_____Cell Phone – Cell phone number ( )_______-_________ Text ______________

I understand that this office will release any information to those persons whom I have determined may receive this information without separate consent. In addition, I understand that this relates to all medical as well as billing information. This will be actively enforced. If you wish to change the status of this form, you must do so in person, in writing, or in the office. A copy of the privacy notice will be given to you upon request.

____________________________________ ____________________

Patient Signature Date

NORTHERN VIRGINIA EAR, NOSE AND THROAT ASSOCIATES
Michael G. Mellis, MD
19465 Deerfield Ave. Suite 301, Leesburg VA 20176 (703)729-8080
1860 Town Center Dr. Suite 225, Reston VA 20190 (703)483-3610

Do you snore? YES/NO
Do you have any allergies to medications? YES/NO
If YES, please list below:

Allergy to medication:	Reaction
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Do you have any environmental allergies? YES/NO
If YES, please list below:

____

Review of Systems: (**Check box or write in symptoms that you CURRENTLY have**)

Constitutional: ☐ None ☐ Fatigue ☐ Weight Loss ☐ Weight Gain ☐ Feve☐ Other_____________
Eye symptoms: ☐ None ☐ Double vision ☐ Blurry vision ☐ Eye Pain ☐ Other____________________
ENT: ☐ None ☐ Congestion ☐ Runny Nose ☐ Sinus Pain ☐ Other ____________________________
Skin: ☐ None ☐ Itchy rash ☐ Dry skin ☐ Hives ☐ Other ____________________________________
Lungs: ☐ None ☐ Cough ☐ Wheezing ☐ Mucous ☐ Other _________________________________
Heart: ☐ None ☐ Chest pain ☐ Shortness of breath ☐ Swelling in legs ☐ Other _________________
Gastrointestinal: ☐ None ☐ Nausea ☐ Diarrhea ☐ Heartburn ☐ Other _________________________
Neurologic: ☐ None ☐ Headaches ☐ Memory Problems ☐ Other______________________________
Immune: ☐ None ☐ Frequent infection ☐ Suppressed ☐ Other______________________________
Psychiatric: ☐ None ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Other____________________________

What are you being seen for at NOVA ENT?

____
____
____

Reviewed by provider _______

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Patient Questionnaire

*The following information is **confidential** and will not be released to anyone without your authorization.*

Patient Name: _______________________________**Date of Birth:** ______________ **Height:** ________ **Weight:** __________

Referring Dr: ____

Pharmacy Name: ______________________________ **Phone:** __________________________

PAST MEDICAL HISTORY: (conditions that you currently have and are being treated for, or conditions that you have been treated for in the past) Examples would be high blood pressure, diabetes, anxiety, depression, sleep apnea, cancer, etc.

PAST SURGICAL HISTORY: Such as tonsillectomy, sinus surgery, appendectomy, heart stent, etc.

FAMILY MEDICAL HISTORY: Are there diseases that run in your family?

SOCIAL HISTORY

Do you smoke cigarettes?	□ No	□ Yes	□ Less then 1 pack/day	□ 1-2 packs/day	□ Quit _______ years ago
Do you drink alcohol?	□ No	□ Yes	□ Prior history of abuse		
Do you use recreational drugs?	□ No	□ Yes			

Medications that you take	Dose	Disease it is treating
1.________________________	_________________	____________________________________
2.________________________	_________________	____________________________________
3.________________________	_________________	____________________________________
4.________________________	_________________	____________________________________
5.________________________	_________________	____________________________________
6.________________________	_________________	____________________________________
7.________________________	_________________	____________________________________
8.________________________	_________________	____________________________________
9.________________________	_________________	____________________________________
10.________________________	_________________	____________________________________

*If you need additional space please attach a list and bring to your appointment.