Patient Name: _____ DOB: _____

Referring Md: _____ Primary Care: _____

Height: _____ Weight: _____

Flu Vaccine: _____ Date Received: _____ Pneumonia Vaccine: _____ Date Received: _____

Tobacco Use: _____ Ppd: (Packs Per Day) _____ Year Started/Quit: _____

Childhood Exposure: _____

Alcohol Use: _____ Prenatal Exposure: _____

Family History: (Illnesses = Mother, Father, Sister, Brother) _____

_____

SOCIAL HISTORY:

Marital Status: _____

Pregnant: _____ Children: _____

Occupation: _____

Past Medical History: _____

_____

Past Surgical History: _____

_____

Medications: (Strength & Dosage) _____

_____

_____

Allergies: _____

_____

REASON FOR VISIT:

Review Of Systems:

Ears: ☐ Infections ☐ Pain ☐ Drainage ☐ Dizziness ☐ Hearing Loss ☐ Ringing

Nose/ Sinus: ☐ Headaches ☐ Polyps ☐ Changes in smell ☐ Dryness ☐ Snoring ☐ Congestion ☐ Drainage ☐ Nose Bleed

Oral: ☐ Sore throat ☐ Mouth breathing ☐ Feeling of lump in throat

Neck: ☐ Hoarseness ☐ Difficulty swallowing

Constitutional: ☐ Fatigue ☐ Fever ☐ Change in weight: _____ LOSS _____ GAIN

Eyes: ☐ Itching ☐ Double vision ☐ Glaucoma ☐ Cataracts

Respiratory: ☐ Chronic cough ☐ Asthma ☐ Shortness of breath ☐ Emphysema ☐ COPD

Cardiovascular: ☐ Heart disease ☐ Prolapsed valve ☐ Extra beats ☐ Swelling in legs ☐ High blood pressure ☐ Heart attack

GI: ☐ Vomiting ☐ Diarrhea ☐ Heartburn/Reflux ☐ Constipation

Neurological: ☐ Numbness ☐ Paralysis ☐ Tremor ☐ Seizures ☐ Blackouts Trauma

Endocrine: ☐ Diabetes ☐ Thyroid disease

Skin: ☐ Rash ☐ Itching

Musculoskeletal: ☐ Pain in neck ☐ Pain in joints

Urinary: ☐ Kidney disease

Psychiatric/Emotional: ☐ Anxiety ☐ Depression ☐ ADHD ☐ ADD

SCREENING ASSESSMENT

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Patient Phone: _____

SYMPTOMS	SEVERITY				FREQUENCY		
	N/A	Mild	Moderate	Severe	Occasionally/ Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

1. Have you ever been diagnosed with asthma, recurrent wheezing, or recurrent bronchitis? ☐ Yes ☐ No

2. Have you ever been diagnosed with atopic dermatitis, eczema, or recurrent sinusitis? ☐ Yes ☐ No

3. Do you take prescription or OTC medications to manage your allergy symptoms? ☐ Yes ☐ No

Check each medication that you use to manage your allergy symptoms:

☐ Allegra (Fexofenadine) ☐ Xyzal (Levocetirizine) ☐ Benadryl (Diphenhydramine) ☐ Zyrtec (Cetirizine)

☐ Claritin (Loratadine) ☐ Singulair (Montelukast) ☐ Clarinex (Desloratadine) ☐ Other: _____

4. Do you take any steroidal or non-steroidal anti-inflammatory drugs? ☐ Yes ☐ No

Check each medication that you use to treat inflammation:

☐ Aleve (Naproxen) ☐ Aspirin ☐ Advil/Motrin (Ibuprofen) ☐ Prednisone ☐ Other: _____

5. Have you ever had a reaction to any foods in the cast? If so, describe the event. ☐ Yes ☐ No

Check the reaction(s) you experienced during the event(s):

☐ Tingling/itchy mouth ☐ Hives/rash/eczema ☐ Swelling ☐ Wheezing/difficulty breathing
☐ Abdominal pain/ diarrhea/nausea/vomiting ☐ Dizziness/lightheadedness/fainting

IF THE ANSWER TO QUESTION 5 WAS "NO," PLEASE SKIP QUESTIONS 6 AND 7.

6. Do you have any family members that have been diagnosed or have suspected allergies? If so, list those family members and their diagnosed/suspected allergies. ☐ Yes ☐ No

7. Have you ever been tested for food allergies? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY:		
Sum of severity of symptoms (0-21)	Sum of frequency of symptoms (0-14)	Order 95004?
		☐ Yes ☐ No
		Check Test(s)
		☐ Environmental ☐ Food
Provider Signature: _____ Date: _____		☐ Environmental & Food

FOOD ALLERGY TESTING ORDER FORM

Check applicable boxes below to indicate the food panels that are being ordered for the patient referenced above:

☐	**Pediatric/ Adult a.** Almond Shrimp Egg Walnut Cow's Milk Peanut Soy Wheat
☐	**Adult b.** Barley Lobster Cod Rye Clam Crab Oat Salmon
☐	**legume and Nut** Almond Peanut Cashew Pistachio Brazil Nut Hazelnut Pecan Walnut
☐	**Shellfish and Fish** Clam Lobster Crab Shrimp Cod Flounder Salmon Tuna

	ICD-10 Code	Code Definition
☐	J30 .5	Allergic Rhinitis due to food
☐	J38.4	Edema of larynx
☐	J39.3	Upper respiratory tract hypersensitivity reaction, site unspecified
☐	K52.29	Other allergy and dietetic gastroenteritis and colitis
☐	L27.2	Dermatitis due to ingested food
☐	LSO.O	Allergic urticaria
☐	ROG.02	Shortness of breath
☐	R0 6.2	Wheezing
☐	T78.00XD	Anaphylactic reaction due to unspecified food, subsequent encounter
☐	T78.00XS	Anaphylactic reaction due to unspecified food, sequela
☐	291.01*	Food allergy status
☐	291.010*	Allergy to peanuts
☐	291.011*	Allergy to milk/milk products
☐	z91.012•	Allergy to eggs
☐	291.013*	Allergy to seafood
☐	291.018*	Allergy to other foods
☐	K90.49	Malabsorption due to intolerance to carbohydrate, fat, protein, or starch
☐	OTHER	Please list:

**Some insurance earners do not accept this ICD-10 code as a primary diagnosis code when billing.*

Provider Signature: _____ Date: _____

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

By signing below, I hereby authorize Central Plains ENT, P.C., to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefits Managers for the purpose of Continued Treatment.

Date of Authorization: _____

_____

Patient/Legal Representative or Parent/Legal Guardian Print Name

_____

Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Central Plains ENT, P.C. may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Pharmacy name and address:

Name: _____

Address/Phone: _____

ACKNOWLEDGMENT OF RECEIPT OF

CENTRAL PLAINS EAR, NOSE, THROAT & AUDIOLOGY CENTER'S NOTICE OF PRIVACY PRACTICES

I have been given a copy of the Central Plains Ear Nose Throat & Audiology Center's ("Central Plains") Notice of Privacy Practices for Protected Health Information. I understand Central Plains has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy at Central office. The undersigned does hereby acknowledge receipt of Central Plains' Notice of Privacy Practices for Protected Health Information.

Dated this day, of _____ , 20 _____.

Patient/Guardian Signature: _____

I authorize Central Plains Ear Nose Throat & Audiology Center to take my photograph for their electronic medical record.

Telephone Release:

If unavailable, I give my consent to release medical information such as (but not limited to) lab results, radiology results, appointment information, etc. to:

☐ Spouse/Partner: _____

☐ Message machine at phone number: _____

☐ Relative: _____

☐ Other: _____

☐ None: _____

Patient/Guardian Signature: _____

FOR OFFICE PURPOSES ONLY:

I made a good faith effort to obtain the patient's acknowledgement of receipt of notice of privacy practices; however, I was unable to obtain the patient's acknowledgment for the following reasons:

_____

Name Signature Date

Thank you for choosing Central Plains ENT & Audiology for your Ear, Nose and Throat needs. We are dedicated to providing exceptional care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. As a courtesy to you, we will file all medical claims with your primary and secondary insurance plans, based upon your authorization to release your plan's benefits to us. All claims are filed within standard HIPAA guidelines. Please review below and contact us if you have any additional questions.

Proof of Insurance: We ask that you bring your insurance card at the time of your visit. This is to ensure we have your most recent insurance information to accurately submit your claim.

Referrals & Authorizations: If your insurance requires a referral or an authorization, it must be in place prior to your appointment or you may be asked to reschedule your visit. It is ultimately the responsibility of the patient/parent/legal guardian to contact your primary care physician (PCP) to obtain a referral, if required. Please contact your insurance company or our referral coordinator to confirm if your plan requires prior authorization to be seen.

Co-payment: If your insurance requires a co-payment, it is due at the time of your visit. They cannot be billed. You may be asked to reschedule your appointment if the co-payment cannot be collected at the time of service. Co-insurance and Deductible payments will also be collected at the time of service, when known. We accept cash, checks, and all major credit cards. There is a $25 service charge for returned checks.

Insurance: Your insurance policy is a contract between you and your insurance company. Central Plains ENT & Audiology is not involved. It is your responsibility to be aware of your insurance plan coverage, eligibility, deductibles, co-insurance and benefits provisions.

Self-Pay Discounts: Central Plains ENT & Audiology offers a 10% discount to uninsured domestic residents of the United States who pay a portion of their estimated bill on or before the date of service. Any remaining balance will be billed to the guarantor (also discounted at 10%). For active insurance policy holders, we also offer a 5% self-pay discount for any procedures or services that may not be covered by your insurance policy. Our self-pay discounts do not apply to deductible or co-insurance balances. To set-up a payment plan, please contact our billing office at 402-502-6970.

In-Office Procedures: In order for the physician to evaluate and/or treat your condition, you may need to have a procedure or use an instrument that your insurance classifies as a "surgical procedure." Some of these types of diagnostic procedures, such as a fiber optic laryngoscopy and endoscopy, may be classified this way and could be applied to your deductible or co-insurance, as an out-of-pocket expense to you, if applicable. This amount is determined by your insurance plan benefits and varies between plans.

Additional Testing: Please note if you require Audiology services, such as a diagnostic hearing test, this is also billed to your insurance company but may require additional co-payments, referrals and could be applied to your deductible or co-insurance as an out-of-pocket expense to you.

Surgical Procedures: If you require a surgical procedure (non-office procedure), please note you will receive separate billing statements from the hospital, surgeon(s) and the anesthesia department.

Post-Surgical Visits: Office visits after surgery that are related to that surgery and are within the "global period" (specific number of days after surgery) are included in the surgical charge and will not require an additional co-payment or referral. If your visit with us falls outside the global period, standard billing practices apply.

Missed Appointments: We understand that occasionally a patient cannot make a scheduled appointment. We ask that you call our scheduling line (402-502-6970) to cancel your appointment at least 24 hours in advance, which allows other patients to be scheduled. If you have missed three appointments without rescheduling, we reserve the right to discharge your care to another health care facility.

Minors: Minors less than 18 years of age must be accompanied by a parent or court-appointed legal guardian for us to treat them.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Responsible Party if a Minor _____ Date _____

Please Print Name of the Patient _____ Date _____