The offices of
JOHN R. SIMPSON, D.D.S, M.D., F.A.C.S.

NORTHEAST GEORGIA ENT-HEAD AND NECK SURGERY, P.C
700 Sunset Dr. Suite 103
Athens, GA 30606
Ph. 706-546-0144
FAX 706-543-9203

WINDER EAR, NOSE THROAT CENTER, P.C.
259 N. BROAD STREET
WINDER, GEORGIA 30680
PH. 770-867-1131
FAX 706-543-9203

Physicians Hearing Centers
Complete hearing aid sales and service
Athens and Winder Locations
1-888-450-EARS

Dear Patient,

Thank you for choosing The offices of John R. Simpson, M.D.,F.A.C.S. This letter and any accompanying paperwork is your Patient Information Packet. Please complete the enclosed forms to the best of your ability and knowledge. These forms should be completed in ink only.

On the day of your appointment please bring:
- Completed Paperwork.
- Your insurance card and picture I.D. You will not be seen without acceptable identification.
- Any office notes, CT scans, XRays, labs that may relate to your visit.
- Your copay if applicable. (We accept all major credit cards, checks or cash.)

It is the patient's responsibility to know if your insurance requires a referral and to obtain the referral and to check with your insurance company to make sure we are in your network.

We will bill your insurance carrier for all covered services if you are covered by a plan we contract with as participating providers. You are required to pay all copays at the time of service. For amounts due after insurance has processed your claim (such as unmet deductibles or noncovered services), you will receive 3 consecutive statements at 30 day intervals. If no payment is received your account will be forwarded to collections. *

As always, we do everything we can to better serve your needs in the most efficient and professional manner. If you have any questions or concerns, please do not hesitate to call us, 706-546-0144.

Patient (or guardian)Signature _____ Date _____

*You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include Prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
*$35.00 returned check fee
*No Show appointments may be charged a $25.00 fee.

Northeast Georgia ENT, Head and Neck Surgery
John R. Simpson, D.D.S., M.D., F.A.C.S.

Patient Information (PLEASE FILL OUT COMPLETELY)

Referring Physician _____ **Primary Care Physician:** _____

If no referring physician, how did you hear about our office? _____

Patient's Legal Name:_____SS# _____ Sex: M F

Address _____ _____ _____ _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell _____

May Medical Information Be Left On Your Answering Machine: ☐ Yes ☐ No

DOB _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other

Patient Employment: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled

Patient Employer/School_____Occupation_____Phone _____

Emergency Contact_____ Relationship_____Phone _____

Guarantor:

Name_____ SS# _____DOB _____

Address _____

Employer_____Phone _____

Primary Insurance:

Insurance Company Name _____Policy Holder Name:_____

Patient's ID# _____ Group # _____

Relationship to Patient _____Social Security #_____DOB _____

Secondary Insurance: ☐ Yes ☐ No

Insurance Company Name _____Policy Holder Name: _____

Patient's ID# _____ Group # _____

Relationship to Patient _____Social Security #_____DOB _____

I hereby authorize that my medical information can be released to the following people:_____

_____

This authorization will remain effective until Dr. Simpson receives a written notice revoking authorization.

Signed _____ Date _____

Health History

Name _____ DOB _____

Reason for today's visit (in detail) _____

_____

Drug Allergies ☐ Yes ☐ No List _____

_____

PAST MEDICAL HISTORY:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding disorders
- ☐ Blood Disease
- ☐ Blurred Vision
- ☐ Cancer Type:_____
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Coronary Artery disease
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Ear Discharge
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hoarseness
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Ringing in Ears
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head or Neck
- ☐ Venereal Disease

List any other disease or conditions:_____

_____

Any family History of Cancer, Heart Problems, etc. ☐ Yes ☐ No If YES list: _____

_____

PREVIOUS SURGERIES: (Please list all surgeries & dates)

- ☐ Appendectomy
- ☐ Cancer surgery
- ☐ Carotid surgery
- ☐ Cervical spine surgery
- ☐ C-Section
- ☐ Ear drum repair
- ☐ Extremity Surgery
- ☐ Gall Bladder
- ☐ Heart bypass
- ☐ Heart stent
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Knee L/R_____
- ☐ Mastoidectomy
- ☐ Pacemaker
- ☐ Removal of neck mass
- ☐ Septoplasty
- ☐ Shoulder R/L_____
- ☐ Sinus surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy & adenoidectomy
- ☐ Tubes in ears
- ☐ Tympanoplasty
- ☐ Wisdom teeth
- ☐ Other_____

_____

Do you drink alcohol? ☐ Yes ☐ No How often?_____ ☐ Beer ☐ Wine ☐ Liquor

Do you smoke? ☐ Yes ☐ No How much per day? _____ ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Other

Have you ever smoked? ☐ Yes ☐ No How long ago did you quit?_____years ago

Do you use smokeless tobacco? ☐ Yes ☐ No How much? _____ Quit ☐ Yes ☐ No How long ago? _____

Do you use or have you ever used illicit drugs? ☐ Yes ☐ No If YES, how much, how often, and what type? _____

_____

Are you pregnant? _____ Due date _____ Are you nursing?_____

Signature of Patient_____ Date _____

Northeast Georgia ENT, Head and Neck Surgery
Winder ENT
John R. Simpson, D.D.S., M.D., F.A.C.S.

MEDICATION RECORD

Patient's Name: _____ D.O.B.: _____ Gender: _____

Drug Allergies: _____

Ever had allergic reactions to Dental Anesthesia (Novacaine)? ☐ Yes ☐ No

Latex Allergies: Yes No

Pharmacy:_____Location:_____Phone:_____

Today's Date	Medication	Dosage

Today's Date	Medication	Dosage

CONSENT TO TREATMENT, AUTHORIZATIONS, AND MEDICAL RELEASE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I authorize The offices of John R. Simpson, MD; Northeast Georgia ENT Head & Neck Surgery, P.C. and Winder Ear Nose and Throat Center and Physicians Hearing Centers, hereafter collectively referred to as ***The Offices*** to give me reasonable and proper medical care by today's standards.
I consent to ***The Offices's*** use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as protected health information or PHI) for the purposes of:

- Providing medical treatment.
- Obtaining payment and reimbursement.
- Obtaining authorizations from my insurance for tests.
- Requesting healthcare services from other providers.
- Cooperating with other providers in my medical treatment.
- Fulfilling requests for information when specifically authorized by me
- Doing all other things directly related to providing healthcare to me.
- Communicating and promoting all locations and services available through The Offices.

The above purposes and all other uses are known collectively as treatment, payment, and other healthcare operations or TPO. I authorize any physician or healthcare facility to provide upon request any PHI to ***The Offices*** when needed for the purposes of TPO. I authorize release of my medical records to ***The Offices*** including human immunodeficiency virus, psychiatric, drug/alcohol records, venereal disease, and other statutory protected diseases as necessary for continued medical care.
I consent to ***The Offices*** discussing any or all of my medical care including my evaluation, treatment, and diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, Human immunodeficiency virus (HIV), HIV related opportunistic infections, pregnancy, billing, or appointments with the following person(s):
PLEASE LIST A SPOUSE OR FAMILY MEMBER TO RELEASE YOUR INFORMATION TO IN THE EVENT YOU ARE NOT ABLE TO RECEIVE THE RESULTS OF ANY EXAMINATION ORDERED BY THE OFFICES.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I consent to allow ***The Offices*** to leave a message on my answering machine or voicemail regarding my appointment, bill, or test results. I also take responsibility for providing enough information for the office staff to contact me efficiently by mail, telephone, and other forms of communication.
My preferred contact phone number is 1._____ 2._____.
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. ***The Offices*** Notice of Privacy Practices and Patient Bill of Rights is posted on the website ***www.johnsimpsonmd.com*** and I may obtain a copy if I so desire by requesting a copy. I understand that should I choose not to consent to the terms and conditions of ***The Offices*** the practice has the right to and will withhold treatment except where required by law.

Patient Name (Print): _____ Date of Birth: _____

Patient Signature (or Guardian) : _____ Date: _____

The health insurance portability and accountability act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other health care operations without a signed consent and prohibits the use and disclosure of protected health information for non healthcare related activities without specific and explicit authorization.