JOHN R. SIMPSON, D.D.S, M.D., F.A.C.S.

EAR, NOSE AND THROAT - HEAD AND NECK SURGERY
ENDOSCOPIC SINUS SURGERY, SLEEP APNEA SURGERY
FACIAL PLASTIC SURGERY

NE GEORGIA ENT
HEAD AND NECK SURGERY, P.C.
700 SUNSET DRIVE, SUITE 103
ATHENS, GEORGIA 30606
TELEPHONE (706) 546-0144
FAX (706) 543-9203

WINDER EAR, NOSE AND THROAT
259 N. BROAD STREET
WINDER, GEORGIA 30680
TELEPHONE (770) 867-1131

Dear Patient,

Welcome, this is your new Patient Information Packet for your upcoming office visit. Please complete the enclosed forms to the best of your ability and knowledge. These forms should be completed in **ink** only. Please bring paperwork to your scheduled appointment.

These are a few items that you will need on the day of your visit:

- **Insurance Card & D.L./Picture I.D. To Every Scheduled Appointment**
- **Any Office Notes, CT Scans, X-Rays, Labs That May Relate To Your Visit**

Please make sure you have a referral for your visit if your insurance requires. **It is the patient's responsibility to know if you need a referral and to obtain the referral. We are not responsible if your benefits do not pay due to lack of referral.** Please check with your insurance company to make sure we are in your network. This is also your responsibility to find this information out.

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 @ **706-546-0144**.

Sincerely,
Office Manager

Your Appointment Date: ____
Your Appointment Time: __________________ Arrival Time ______________
Your Appointment is Scheduled in the _____________________________ Office

Please call our office 24 hours in advance if you are unable to keep your appointment. A broken appointment is a loss to everyone.

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

Patient Information

Referring Physician ____________________ **Primary Care Physician:** ____________________

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

Patient's Name: ____________________ SS# ____________________ Sex: M F

Address ____________________

Home Phone ____________________ Work Phone ____________________ Cell ____________________

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

DOB ____________________ Marital Status ____________________

Patient Employment: Employed Retired Unemployed Student Disabled

Patient Employer/School ____________________ Phone ____________________

In Case of an Emergency Contact ____________________ Phone ____________________

Guarantor:

Name ____________________ SS# ____________________ DOB: ____________________

Address ____________________

Employer ____________________ Phone ____________________

Primary Insurance:

Insurance Company Name ____________________ Policy Holder: ____________________

Patient's ID# ____________________ Group # ____________________

Relationship to Patient ____________________ Social Security # ____________________ DOB: ____________________

Secondary Insurance: Yes / No

Insurance Company Name ____________________ Policy Holder: ____________________

Patient's ID# ____________________ Group # ____________________

Relationship to Patient ____________________ Social Security # ____________________ DOB: ____________________

Please List Names Of Anyone (including physicians) That We Can Release Medical Information To:

____

____

____

Signature of Patient/Guardian ____________________ Date ____________________

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Health History

Name ______________________________ DOB ______________

Reason for today's visit (in detail) ______________________________

____

Are you allergic to any medications? Yes _____ No _____ If YES list: ______________

Have you ever had a dental anesthesia (Novocaine)?______________ Any bad reactions?________

CIRCLE ALL THAT APPLY:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back problems
☐ Bleeding abnormally, during surgery
☐ Bleeding Gums
☐ Blood Disease
☐ Blurred Vision
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Hear Lesions
☐ Cortisone Treatments
☐ Cough, persistent or bloody
☐ Crossed Eyes
☐ Diabetes
☐ Difficulty Swallowing
☐ Double Vision
☐ Ear Discharge
☐ Emphysema
☐ Epilespy
☐ Fainting or Dizziness
☐ Glaucoma
☐ Hay Fever
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hepatitis Type __________
☐ Herpes
☐ High Blood Pressure
☐ Hoarseness
☐ Jaundice
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Loss of Hearing
☐ 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
☐ Skin Rash
☐ Special Diet
☐ Stroke
☐ Swollen Feet or Ankles
☐ Swollen Neck Glands
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumor or Growth on Head or Neck
☐ Venereal Disease

List any other disease or conditions:______________________________

____

List **ANY** surgeries you have had and dates: ______________________________

____

Do you drink alcohol? Yes / No How often? ______________________________

Do you smoke? Yes / No If YES, how much? ______________________________

Do you use smokeless tobacco? Yes / No If YES, how much? ______________________________

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 ______________________

RELEASE INFORMATION- I authorize the release of medical information to my primary care, referring, or consulting physicians. We will only send medical information to the physicians that are listed on your information sheet. I also give permission to give medical information to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physicians.

PAYMENT POLICY - Co-pays and deductibles are due at time of service for those insurance policies we are contracted with. For those insurance policies that we are not contracted with, we will gladly file your insurance claim however; payment will be requested at time of service. If your insurance requires a referral, it is the patient's responsibility to make sure we have the referral before your appointment time. It is your responsibility to ensure that we are contracted with your insurance. We are not contracted with Medicaid, Wellcare, AmeriGroup or any other insurance relating to Medicaid. Private pay patients will be required to pay in full at time of service. There is a $35.00 return check fee on any check that is returned to our office.

MEDICARE - We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying 20% co-payment at the time of service. We will bill secondary/supplemental carriers. However, in the event that the secondary carrier does not pay within 60 days, patient will be billed.

NO-SHOW APPOINTMENTS - An appointment confirmation call will be made 1 to 3 days prior to your scheduled appointment date and time. Due to the increased volume of no-show appointments we will charge you a $25.00 fee to your account. If this is not paid it will be turned over for collections. It is the patient's responsibility to inform our office of any changed phone numbers and/or addresses.

**** If you do not pay your bill or attempt to make payment arrangements, you will be turned over to collections!

By signing below, I agree that I have read all of the above information and understand.

____________________________ ____________________________

Patient/Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
DR. JOHN R. SIMPSON

I understand that, under Health Insurance Portability & Accountability Act of 1996 (‘HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have received your Notice of Privacy practices, or is readily available, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ______________________________________

Signature ____

Date____

NORTHEAST GEORGIA ENT HEAD & NECK SURGERY

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: ______________________

Latex Allergies: Yes No

Pharmacy: ______________________ Phone: ______________

Date	Medication	Dsg	Discontinue	Date	Medication	Dsg	Discontinue

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