Vinod K. Anand, MD, FACS
Nose and Sinus Clinic

New Patient Medical History Questionnaire

Personal Information

Name: ______________________________ Sex: _________ Age: _________

Occupation: __________________________

Reason for this appointment: ____

____

____

Medical Information

Name of Referring Physician: ______________________________________

Name of Primary Care Physician ___________________________________

Have you ever experienced an unusual or allergic reaction to any medicines? YES NO

If yes, please list ____

____

Are you now taking any medicine (including shots)? YES NO

Please list with dosage amount ______________________________

____

____

Have you ever been seriously sick or hospitalized for illness, surgery, or other conditions? YES NO

Hospitalizations: ____________________________________

Surgery/Operations: __________________________________

____

Do you now have, or have you ever had the following:

Heart trouble or murmur	YES	NO
Rheumatic fever	YES	NO
Stomach/duodenal ulcer	YES	NO
Stroke	YES	NO
High blood pressure	YES	NO
Diabetes (high blood sugar)	YES	NO
Kidney problems	YES	NO

Do you now have, or have ever had the following: (continued)

Hepatitis or liver disease	YES	NO
Convulsion or epileptic seizures	YES	NO
Bleeding disorder	YES	NO
Sickle cell disease or trait	YES	NO
Anemia	YES	NO
Thyroid disease	YES	NO
Tumor or cancer	YES	NO
Asthma	YES	NO
Tuberculosis	YES	NO
Emotional problems, treated by medication or hospitalization	YES	NO
Venereal disease, syphilis, gonorrhea, etc..	YES	NO
Hearing loss	YES	NO
Glaucoma	YES	NO
Physical handicap	YES	NO

Have you ever used Cocaine, marijuana, heroin or similar drugs? YES NO

Have you ever smoked or used tobacco in any form? YES NO
Are you currently smoking or using any tobacco in any form? YES NO

If so, how much?____________________________________

Have you ever drank alcoholic beverages? YES NO

If so, how much?____________________________________

Have you any reason to suspect that you may have been exposed to the HIV Virus (AIDS)? YES NO

IS THERE ANYTHING WE SHOULD KNOW ABOUT YOUR HEALTH THAT IS NOT COVERED BY THESE QUESTIONS? YES NO

If so, please explain____

Patient or Guardian Signature_________________________________Date_______________

PHYSICIAN SIGNATURE_________________________________Date_______________

Vinod K. Anand, M.D., F.A.C.S.
501 Marshall Street, Suite 602
Jackson, Mississippi 39202

Date:________________

Name:_____________________________________

1. Do you have any difficulty communicating with others? If yes, how long? ______________	YES	NO
2. Do you have difficulty communicating in noisy situations?	YES	NO
3. Do you hear better out of one ear? If yes, which one? _____________	YES	NO
4. Do you have ringing in you ear(s)? If yes, which one? L R Both	YES	NO
5. Do you ever experience dizziness?	YES	NO
6. Do you ever have any pain in you ear(s)?	YES	NO
7. Have you ever been exposed to noise (industrial, gunfire)?	YES	NO

Nose and Sinus Clinic ♦ 501 Marshall St, Suite 602 ♦ Jackson, MS 39202

NEW PATIENT INFORMATION

DATE:______________________________ EMAIL ADDRESS:____

DO WE HAVE YOUR PERMISSION TO USE YOUR EMAIL FOR CORRESPONDENCE SUCH AS MONTHLY STATEMENTS? YES__________ NO___________

PATIENT NAME:____ AGE:__________ BIRTHDATE:____________________
LAST FIRST MI

ADDRESS:____ CITY:__________________ STATE:________ ZIP:___________

SS#_________________________ SEX: M F MARITAL STATUS: S M W D SEP. OCCUPATION:____________________

CELL PHONE:__________________________ HOME PHONE:______________________ WORK PHONE:____________________

EMPLOYER:____________________________________ EMPLOYER ADDRESS____

PHARMACY NAME:____________________ ADDRESS:_________________________ PHARMACY PHONE:________________

SPOUSE'S NAME______________________________________ SS#____________________ BIRTHDATE___________________
LAST FIRST MI

ADDRESS:_______________________________________ CITY____________________ STATE:_________ ZIP:____________

EMPLOYER:___________________________________ EMPLOYER ADDRESS:____

WHO CAN WE CALL IN CASE OF AN EMERGENCY?:____

PHONE:____ RELATIONSHIP:____

IF THE PATIENT IS A MINOR:

MOTHER'S NAME:___________________________________ SS#____________________ BIRTHDATE:__________________

ADDRESS:____ CITY:__________________ STATE:________ ZIP:___________

EMPLOYER:____ EMPLOYER ADDRESS:____________________________________

OCCUPATION:____ WORK NUMBER:_____________________________________

FATHER'S NAME:______________________________ SS#______________________________ BIRTHDATE:______________

ADDRESS:____ EMPLOYER ADDRESS:______________________________________

OCCUPATION:____ WORK NUMBER:______________________________________

____
SIGNATURE (INSURED OR AUTHORIZED PERSON)

FINANCIAL RESPONSIBLITY

I REQUEST THAT PAYMENT OF MEDICARE OR ANY OTHER INSURANCE CARRIER BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIAN(S) OF THE NOSE AND SINUS CLINIC FOR ANY SERVICES FURNISHED BY DR. VINOD K. ANAND AND/OR DR. BARRIE ADEN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER AND OR ITS AGENS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ALL DEDUCTIBLE AND ALL CO-INSURANCE AMOUNTS. IF THE NOSE AND SINUS CLINIC DOES NOT PARTICIPATE IN MY INSURANCE PLAN, RENDERING THIS OFFICE INELIGIBLE FOR PAYMENT OR MY INSURANCE DEFAULTS IN PAYMENT OF ANY KIND FOR ANY REASON, I AM FULLY RESPONSIBLE FOR ALL COST INCURRED IN THE COLLECTION OF THIS AND FUTURE OUTSTANDING BALANCES.

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

PATIENT/RESPONSIBLE PARTY:____ DATE:______________________________

WE WILL MAKE A COPY OF YOUR INSURANCE CARD ALONG WITH YOUR I.D.

Nose and Sinus Clinic
501 Marshall Street, Suite 602
Jackson, Mississippi 39202

FINANCIAL RESPONSIBILITY:

I understand that all services rendered are my financial responsibility and that payment is due at time of treatment unless prior arrangements have been made. In consideration of the practice accepting the above patient for service, and of the services rendered or to be rendered to him or her the undersigned guarantees payment of the account of such patient and agrees to pay the same if not paid by the patient at the time of service.

Responsible Party: ___________________________________ Date: ______________

RELEASE OF MEDICAL INFORMATION:

This is your authority to release medical information to my insurance companies, or my attorney if disability related, or my employer and their workman's compensation carrier if a job related injury.

Responsible Party: ____ Date: _______________

MEDICARE:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the medical practice of Dr. V. K. Anand for any services furnished to me. I authorize any holder of medical information about me to release to the health care finance administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the Medicare Administration to release to the medical practice of Dr. V. K. Anand any information regarding Medicare claims for services provided by the practice. This release shall be effective for a period of twelve months from the date of service.

COMMERCIAL INSURANCE:

I hereby authorize the medical practice of Dr. V. K. Anand to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the medical practice of Dr. V. K. Anand, and direct my insurance carrier or it's intermediaries to issue payment checks directly to Dr. V. K. Anand. I understand that I am financially responsible to Dr. V. K. Anand for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Patient / Responsible Party: _________________________________ Date: _______________

♦ NOSE AND SINUS CLINIC♦
VINOD K. ANAND, M.D.,F.A.C.S.
♦ 501 MARSHALL STREET ♦ SUITE 602 ♦ JACKSON, MS 39202
♦ TELEPHONE 601-969-1910 ♦ FAX 601-969-1913

Consent of Treatment

By signing this form, I am granting consent to The Nose and Sinus Clinic, to use and disclose my protected health information for the purposes of treatment, payment and health care operations. I give my permission to The Nose and Sinus Clinic, to administer treatment and perform necessary minor operative procedures in diagnosing and or treating my condition. With this consent The Nose and Sinus Clinic may call and leave a voice mail or in person in reference including mail, and email to my home or other alternative location any items that assist the practice in carrying out my treatment, payment and/or health care operations, such as appointment reminders, insurance items, patient statements, laboratory and/or radiology test results, among others.

You have the legal right to review our Notice of Privacy practices before you sign this consent and we encourage you to read it in full. (You have the right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.)

I agree to be personally and fully responsible for payment. If The Nose and Sinus Clinic does not participate in my insurance plan, rendering this office ineligible for payment or in case of default in payment of any kind for any reason I will be responsible for all cost incurred in the collection of this and future outstanding balances.

Signature____Date________________

♦ NOSE AND SINUS CLINIC♦

VINOD K. ANAND, M.D.,F.A.C.S.

♦ 501 MARSHALL STREET ♦ SUITE 602 ♦ JACKSON, MS 39202

♦ TELEPHONE 601-969-1910 ♦ FAX 601-969-1913

AUTHORIZED RELEASE OF MEDICAL RECORDS

DATE:__________

TO: ____

Fax Number: _________________________________

I hereby authorize you to release my medical records to:

Nose and Sinus Clinic
Vinod K. Anand, M.D., F.A.C.S.
501 Marshall Street, Suite # 602
Jackson, MS 39202

Print Name of Patient: ________________________________

Patient's Complete Current Address: ________________________________

Patient's Date of Birth: ________________________________

Patient's Signature: ________________________________

♦ NOSE AND SINUS CLINIC♦

VINOD K. ANAND, M.D.,F.A.C.S.

♦ 501 MARSHALL STREET ♦ SUITE 602 ♦ JACKSON, MS 39202

♦ TELEPHONE 601-969-1910 ♦ FAX 601-969-1913

In order to coordinate your medical care we need to obtain any and all tests and scans that you have had recently that will be pertinent in your examination today.

	Performed at:	Ordering Physician:	Date:
X-rays	______________	______________________	____________
Ct Scans	______________	______________________	____________
MRI	______________	______________________	____________
Doctor's Records	______________	______________________	____________

________ **I HAVE NOT had any recent tests, or evaluations by other physicians that would help in my treatment today.**

Signature____________________________________**Date**____________