MARLOWE MD
& MARRS MD
ENT + AESTHETICS

Today's date:	Primary Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred name:	Social Security Number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Primary address:	City/State:	Zip Code:
Secondary address:	City/State:	Zip Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

COMMUNICATING WITH YOU

Please check all boxes that you give Marlowe & Marrs ENT permission to use for your communications:

Home Phone Number:	Cell Phone Number:
○ You may contact me by telephone ○ You may leave a voicemail	○ You may contact me by text message

E-mail: *This will give you access to your records through the portal

If you give permission for us to communicate with anyone else, please complete the list below:

Name:	Relationship:	○ Medical/ Health ○ Appointment ○ Billing
Name:	Relationship:	○ Medical/Health ○ Appointment ○ Billing

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Andrew Marlowe, MD, PA, Chad Marrs, MD or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

CLINICAL HISTORY

PATIENT IDENTIFICATION

FIRST NAME: MIDDLE: LAST NAME: DATE OF BIRTH: / /

PHARMACY AND LOCATION:

PRIMARY PHYSICIAN:

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS

SYMPTOM: _____ LOCATION: _____ DURATION: _____

DATE SYMPTOM(S) BEGAN: ___/___/___ RECENTLY SYMPTOM(S) HAVE BEEN: O MORE/O LESS FREQUENT O MORE/O LESS INTENSE
O CONTINUOUS O PERIODIC

HOW DID SYMPTOMS START:_____

WHAT BRINGS IT ON:_____ WHAT RELIEVES IT:_____

WHAT MAKES IT WORSE:_____ ASSOCIATED SYMPTOMS:_____

MEDICATIONS – LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING "OVER THE COUNTER"

DRUG NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

ALLERGIES- LIST ALL OF YOUR MEDICAL ALLERGIES AND THE REACTION

ALLERGIES	ALLERGIC REACTION

PAST MEDICAL HISTORY

LIST ALL ILLNESSES, INJURIES &OPERATIONS	DATE	TREATMENT	PHYSICIAN

FAMILY HISTORY- ALL BLOOD RELATIVES

LIST BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	ILLNESSES	SIMILAR SYMPTOMS?
MOTHER					
FATHER					
SIBLING(S)					

MARLOWE & MARRS ENT/ CLINICAL HISTORY

SOCIAL HISTORY- PLEASE CHECK THE APPROPRIATE BOXES AND FILL IN ACCURATE AMOUNTS OF STANDARD PORTIONS

Mental Work	Physical Work	Exercise	Alcohol	Smoking
❒ Heavy ❒ Omit ❒ Moderate ❒ Light ❒ None No. Hours Per Day: _____	❒ Heavy ❒ Omit ❒ Moderate ❒ Light ❒ None No Hours Per Day: _____	❒ Heavy Type: _____ ❒ Moderate _____ ❒ Light ❒ None No. Hours Per Week: _____	❒ Beer /Week: _____ ❒ Liquor/Week: _____ ❒ Wine /Week: _____ No. Of Years: ____ ❒None	❒ Current ❒ Previous No. Of Packs / Day: No. of Years: ___ Quit Yr:____ Other: _____ ❒ None

Caffeine	Aspirin	Nutritional Information	Miscellaneous Drugs
❒ Coffee ❒ Tea ❒ Cola ❒ Other: _____ Cups Per Day: _____ No. Of Years: _____ ❒ None	No. Per Day: _____ No. Of Years: _____ Other: _____ ❒ None	❒ Low Sodium Diet ❒ Diabetic Diet ❒ Low Fat Diet ❒ Low Carb Diet ❒ Low Cholesterol Diet ❒ Other: _____	❒ Vitamins ❒ Pain Pills ❒ Marijuana ❒ Laxatives ❒ Sleeping Pills ❒ Cocaine ❒ Antacids ❒ Nutrasweet ❒ Amphetamines ❒ Diet Pills ❒ Saccharin ❒ Other_____

REVIEW OF SYMPTOMS - CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY.

GENERAL :	☐ WEAKNESS	☐ FATIGUE	☐ MALAISE	☐ CHILLS	☐ NIGHT SWEATS	☐ FAINTING
	☐ DIZZINESS					
SKIN :	☐ COLOR CHANGES	☐ RASHES	☐ ITCHING	☐ SORES	☐ DRYNESS	
HEAD :	☐ HEADACHES	☐ INJURIES	☐ BUMPS			
EYES :	☐ BLURRED VISION	☐ REDNESS	☐ ITCHING	☐ BURNING	☐ SWELLING	☐ PAIN ☐ DRYNESS
	☐ TEARING					
EARS :	☐ HEARING LOSS	☐ RINGING	☐ DISCHARGE	☐ EARACHE	☐ ITCHING	☐ PLUGGED/BLOCKED/FULLNESS
	☐ PRESSURE	☐ FLUCTUATION OF HEARING		☐ PAIN	☐ HEARING NOISES	
NOSE :	☐ DECREASED SMELL	☐ BLEEDING	☐ PAIN	☐ DISCHARGE	☐ OBSTRUCTION	☐ POST NASAL DRIP
	☐ DEVIATED SEPTUM	☐ RUNNY NOSE	☐ SINUS CONGESTION		☐ NASAL CONGESTION	☐ SNORING
MOUTH :	☐ BLEEDING GUMS	☐ SORES	☐ DENTAL PROBLEMS		☐ PAIN	☐ BAD BREATH
	☐ LOSS OF TASTE	☐ DRYNESS	☐ ULCERS ☐ BLISTERS			
THROAT :	☐ SORE THROAT	☐ BAD TONSILS	☐ HOARSENESS	☐ PAIN	☐ HARD TO SWALLOW	
	☐ RECURRENT INFECTIONS		☐ WHITE SPOTS			
NECK :	☐ ENLARGEMENT	☐ STIFFNESS	☐ SORENESS	☐ PAIN	☐ LUMPS	☐MASSES
LUNGS :	☐ COUGH	☐ PHLEGM	☐ COUGHED BLOOD	☐ SHORTNESS OF BREATH		☐ WHEEZING
	☐ PAIN IN LUNGS	☐ CHEST CONGESTION		☐ INHALANT EXPOSURE		
HEART :	☐ MURMUR	☐ PALPITATIONS	☐ RAPID HEARTBEAT	☐ SWOLLEN EXTREMITIES		☐ CHEST PAINS
	☐ BLOOD CLOTS					
GASTROINTESTINAL :	☐ ABDOMINAL PAIN	☐NAUSEA	☐ VOMITING	☐ BLOATEDNESS	☐ BELCHING	
	☐ HEARTBURN	☐ INDIGESTION				
NEUROLOGICAL :	☐ SEIZURES	☐ VERTIGO	☐ LOSS OF FACIAL EXPRESSION		☐ PARALYSIS	
	☐ SLURRED SPEECH	☐ TINGLING/BURNING/NUMBING	☐ DISORENTATION			
ENDOCRINE :	☐ WEIGHT LOSS	☐ WEIGHT GAIN	☐ HOARSENESS	☐ VOICE CHANGES	☐ HYPOGLYCEMIA	☐ DIABETES
PSYCHIATRIC :	☐ HYPERVENTILATION	☐ ALCOHOL ABUSE	☐ DRUG USE	☐ PANIC DISORDER		☐ DEPRESSION

Please Send Records To:
Andrew Marlowe, M.D. – Chad Marrs, M.D.
5432 Bee Ridge Road Suite 150, Sarasota, FL 34233
Phone: 941-379- EARS (3277) Fax: 941-379-6277

Patient Name: _____ Date of Birth: _____

Requesting Records From: _____

Address: _____

Phone: _____ Fax: _____

For the following purpose: _____ Consultation _____ Continuation of Care

Include the following Records: _____ All Records _____ Office Notes

_____ Hospital Records _____ Laboratory Results

_____ Audiology Records _____ CT Scan

_____ Other: _____

The following items ***must be initialed*** to be included/ disclosed:

_____ HIV/AIDS related information _____ Psychotherapy notes _____ Mental Health records

_____ Genetic Testing records _____ Drug/ Alcohol diagnosis, treatment, or referral

Federal regulations require a description of how much and what kind of information is to be disclosed.

Description: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and may no longer be protected by these regulations. The recipient may, however, be prohibited from redisclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I, therefore, release Andrew Marlowe, M.D, P.A., it's employees, and Dr. Marlowe from all liability arising from the Authorization for disclosure of my protected health information.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so. *This item is not required if the disclosure is requested by the patient*.

I further understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits. I may inspect or copy any information to be used and/or disclosed under this Authorization. *This item is not required if the disclosure is requested by the patient*.

Finally, I understand that I may revoke this Authorization any time, provided that I do so ***in writing***, except to the extent that action has already been taken in reliance upon this Authorization. Unless revoked earlier, this Authorization will expire 180 days from the date of signing.

_____ _____

Signature of Patient or Legal Representative Date Signed

_____ _____

Print Patient Name or Legal Representative Relationship to Patient

MARLOWE MD
& MARRS MD
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PATIENT RELEASE INFORMATION

(Please read carefully. This form must be signed.)

1.

To make our care more efficient, we will require you to present your insurance cards at each visit. We will not file insurance without the presentation of your cards. If you do not have your cards the visit will not be billed to your insurance, and you will be expected to pay for the visit that day of service. The receptionist will also require you to verify your information each time your visit our office. This is to benefit you as the patient and our office so that our records are always up to date and your insurance company can pay the claims in a timely fashion. It is also to ensure that we are taking every possible measure to protect and guard against identity theft.

2.

You understand that Marlowe & Marrs ENT is a specialty practice, meaning that beyond our control some patients will need the attention of the doctor longer than others. We strive to schedule appointments as accurately as possible to provide for our patient's needs. Sometimes you will experience a wait. Understand that the doctors try to allow the time needed to properly care for you as a patient and ask that you understand when these circumstances arise. If the wait becomes too long, we will gladly reschedule your appointment.

3.

As a patient you may be recommended to have lab work, x-rays, MRI's, CT's, or surgery. It is the responsibility of the patient to determine which facility from our recommended list is best covered by your insurance plan. You may receive a bill from the facility providing the service.

4.

As a patient you give permission and consent for the doctors to obtain and provide release of medical records. Due to HIPAA, additional paperwork is required. Our office requires a 72-hour notice to process the request for the records to be faxed and/or copied. There may be a charge for the release of copied records.

5.

If you have insurance, our office will file to your insurance as a courtesy. We suggest that you call your insurance company and confirm that the doctors participate and what your patient responsibility is for a specialist visit. If there is a denial from your insurance, the bill will be applied to patient responsibility.

6.

Payment or co-payment is due at the time of service. If your account should be turned over to a collection agency you understand that additional fees may apply. We have a $30.oo returned check fee for each check in the event your bank does not honor it. If we send your account to collections, there will be an additional 30% charge added to your balance.

7.

Our office is required by law to maintain the privacy of your protected health information and to provide you with a notice about our legal duties and privacy practices regarding the information we collect and maintain for you. As required by laws, a copy of our Notice of Privacy Practices has been provided to you at the time of your visit. In that notice we describe, among other things, how medical information about you may be used and disclosed and how you can get access to this information. The law also requires us to obtain your acknowledgement that we have provided you with our Notice of Privacy Practices. It is for that reason we ask you to read and sign this form. If you have any questions about the Notice of Privacy Practices that we provided to you, please contact our Privacy Officer, Stephanie King, who is on duty at this office and who may also be reached by calling (941) 379-2177. By your signature on this form, you are acknowledging that you have received and understand the Notice of Privacy Practices we have provided to you. A copy of this signed acknowledgement will be maintained in your medical chart.

Signature: _____

Date: _____

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Notice of Privacy Practices Patient Acknowledgement
Effective 03/10/2022

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Marlowe & Marrs ENT. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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.

The Notice of Privacy Practices is subject to change. If the Notice of Privacy Practices is changed, you may obtain a revised copy by visiting our website at http://www.marlowemd.com or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from Marlowe & Marrs ENT

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY
I attempted to obtain the patient's signature of this Notice of Privacy Practices form but was unable to do so.

Date: _____ Name: _____
Reason: _____

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5432 Bee Ridge Rd , Suite 150, Sarasota, FL 34233

Welcome to our practice! We appreciate the opportunity to provide you with the best healthcare and services. Our staff is made up of well trained professionals, who work together as a team to bring you the highest quality treatment. We have put this letter together to introduce you to our practice and answer the most common questions.

APPOINTMENTS

We see patients on an appointment basis, however being a specialty office we have times of emergency work ins. We always try our best to see each patient on time; if we fall short due to emergencies we apologize in advance and are happy to reschedule your appointment if necessary. We ask if you need to cancel an upcoming appointment that you give us 24-hour notice so we have time to offer that appointment slot to another person in need.

OFFICE HOURS

The office is open Monday – Friday from 8:00 am to 5:00 pm.

COMMUNICATING

We offer many secure ways to contact us. For your convenience you can text us at 941-417-5836. It's a great way to make appointments, send us photos of an area of concern, and ask questions. You can also send us a secure message through your patient portal or our website: www.marlowemd.com. This is a quick way to not only request an appointment or medication refill, but you can also access your records! Don't worry we still have our good ole fashion phones so you can reach us at 941-379-3277.

HEARING AIDS

We offer a large selection of hearing aids that consist of many brands and all price ranges. We have the latest technology in hearing aids including Earlens. Most importantly, our staff of audiologists work side by side with our physicians and are ready to help you with the highest level of professionalism.

AESTHETICS

Our aesthetics department is like the rest of our practice, cutting edge and physician directed! We offer all of the latest technology for body sculpting, skin rejuvenation, skin tightening and tattoo removal. We also offer injectables and our medical grade skincare to help you maintain your healthy and youthful appearance.

EMERGENCY CARE

We recognize emergency situations do arise and we will do everything in our power to respond to your problem as quickly as possible. If an emergency arises when the office is closed please call our main office line 941-379-3277 and follow the prompts to speak with our on call service. If an emergency arises when the office is open please call as soon as possible. We have special times for those patients with true emergency needs and you will be seen as quickly as possible.

FINANCIALS

Medical insurance is intended to cover portions of; but not all of the cost of your medical care. **Most plans include co-insurance, copay, deductibles and other expenses that must be paid by the patient.** If you have medical insurance please make sure to bring your insurance card and ID to each appointment. All patient financial responsibility will be collected at the time of service.