MARLOWE MD
ENT + AESTHETICS

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 you 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 that we are taking every possible measure to protect and guard against identity theft.

2. You understand that Dr. Marlowe and Dr. Houle are specialists, meaning that beyond our control some patients will need the attention of the doctor longer than others. We always strive to schedule appointments as accurately as possible to provide for each patient's needs. However, sometimes you will experience a wait. You 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. Please tell the receptionist if the wait is too long and we will gladly reschedule your appointment.

3. As a patient you may be recommended to have lab work, x-rays, MRI's or surgery. We leave the responsibility to the patient that you provide us with the facilities that participate with your insurance company. Failure to do so may result in us using the facility of our choice. 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 release 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 with your insurance. If there is an insurance denial, the bill will be applied to the patient's responsibility.

6. Payment or co-payment is due at the time of service. We have a $30.00 returned check fee for each check in the event your bank returns a personal check. You understand that your insurance may leave a balance as patient responsibility; if this should happen payment is due to Dr. Andrew Marlowe for services rendered. 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 about you. As required by law, a copy of our Notice of Privacy Practices has been provided to you at the time of your visit. In that notice we described, 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 this 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, Jeanne Marlowe, who is on duty at this office and who may also be reached by calling **(941) 379-3277**.

By your signature on this form, you acknowledge that you have received and understand the Notice of Privacy Practices we have provided you. A copy of this signed acknowledgement will be maintained in the medical chart that we maintain for you in this office.

SIGNED_____ **DATE**_____

MARLOWE EAR NOSE & THROAT
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

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

Home phone no.:	Cell phone no.:	Social Security no.:	Birth date:	Age:	Sex:

Primary address:	City/State:	Zip Code:

Secondary address: Email address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

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:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Social Security No:	Daytime phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Please indicate primary insurance	❑ Medicare	❑ Aetna	❑ BC/BS	❑ United	❑ Healthease
❑ Humana	❑ Railroad Medicare	❑ Staywell	❑ Vocational Rehab.	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Specialist Co-Payment $	Policy no.:	Group no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Please list who you would like us to grant access to your private information:

IN CASE OF EMERGENCY:

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell/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 or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CLINICAL HISTORY / MARLOWE EAR NOSE & THROAT

PATIENT IDENTIFICATION

FIRST NAME: _____ MIDDLE:_____ LAST NAME: _____ SSN:_____-____-_____

DATE OF BIRTH: ____/____/____ GENDER: ❒ M ❒ F ❒ OTHER PRIMARY PHYSICIAN _____ REFERRED BY_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____-_____ WORK PHONE: ( ) _____-_____ HISTORIAN _____

OCCUPATION: _____ MARITAL STATUS: _____ NO. OF CHILDREN:_____

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS (TO BE COMPLETED BY THE PHYSICIAN OR ASSISTANT)

SYMPTOM: _____ LOCATION: _____ DURATION: _____

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

HOW DID SYMPTOM(S) START: _____ HOW DID SYMPTOM(S) PROGRESS: _____

WHAT BRINGS IT ON: _____ WHAT RELIEVES IT: _____

WHAT MAKES IT WORSE: _____ ASSOCIATED SYMPTOM(S): _____

CHECK THE ONE(S) WHICH BEST DESCRIBE YOUR PAIN: ❒ SEVERE ❒ MODERATE ❒ MILD ❒ CONTINUOUS ❒ PERIODIC ❒ INTERMITTENT ❒ BURNING ❒ NEEDLE-LIKE ❒ CRAMPING ❒ STABBING ❒ DEEP ❒ SHARP ❒ DULL ❒ SUPERFICIAL ❒ GNAWING ❒ SUDDEN ❒ GRADUAL ❒ SHIFTING ❒ OTHER _____

MEDICATIONS – LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING WITH DOSAGE AND FREQUENCY (INCLUDE "OVER THE COUNTER MEDICATIONS"

DRUG NAME (GENERIC/BRAND)	DOSAGE	FREQUENCY	STATUS
			❒ CHRONIC ❒ ACUTE ❒ DC'D
			❒ CHRONIC ❒ ACUTE ❒ DC'D
			❒ CHRONIC ❒ ACUTE ❒ DC'D
			❒ CHRONIC ❒ ACUTE ❒ DC'D
			❒ CHRONIC ❒ ACUTE ❒ DC'D
			❒ CHRONIC ❒ ACUTE ❒ DC'D

ALLERGIES – LIST YOUR ALLERGIES INCLUDING ANY MEDICATIONS THAT CAUSED AN ALLERGIC REACTION

LIST ALL ALLERGIES	ALLERGIC REACTION

PAST MEDICAL HISTORY – PLEASE PROVIDE A COMPLETE HISTORY INCLUDING ALL ILLNESSES, INJURIES, HOSPITALIZATIONS AND OPERATIONS

LIST ALL ILLNESSES, INJURIES & OPERATIONS	DATE	HOSPITAL	TREATMENT	PHYSICIAN

FAMILY HISTORY – PLEASE LIST ALL BLOOD RELATIVES WITH THEIR CURRENT HEALTH STATUS, ILLNESSES, AGE IF LIVING, AGE AT DEATH & CAUSES OF DEATH

LIST BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	ILLNESSES	SIMILAR SYMPTOMS?
MOTHER					
FATHER					
SIBLINGS					

CLINICAL HISTORY MARLOWE EAR NOSE & THROAT

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 ❒ Vegetarian 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	LOSS OF BALANCE	
DIZZINESS	SPINS						
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			