accent
Physician Specialists

History and Physical Form

NAME: _____ **Date of Birth:**_____ **DATE:** _____

REASON FOR VISIT: _____

HOW LONG HAS IT BOTHERED YOU?_____

REFERRING PHYSICIAN/PRIMARY CARE DOCTOR? _____

PAST MEDICAL HISTORY:

Please check all the conditions that apply to you, comment if necessary.

Problem:	YES	NO	Comment:
Allergies			
Anesthesia Problem			
Asthma			
Bleeding Problems/			
Cancer (Type)			
Diabetes			
Emphysema/ COPD			
Hearing Loss			
Heart Attack/ MI			
Heart Disease			
High Blood Pressure			
Parathyroid Disease			
Seizures			
Thyroid Disease			
Other			

PAST SURGICAL HISTORY:

List past surgeries, the date they took place and if there were any complications.

Surgery:	Date:	Problem:
Hospitalizations:	**Date:**	**Problem:**

SOCIAL HISTORY:

Occupation: _____

Do you currently use (or have in the past) any of the following products?

PRODUCT	YES	NO	AMOUNT	HOW LONG	WHEN QUIT
Cigarettes					
Cigars					
Chewing Tobacco					
Alcohol					
Street Drugs					
Caffeine					

FAMILY HISTORY:

Please check all the conditions that apply to you, comment if necessary.

PROBLEM	YES	NO	WHICH FAMILY MEMBER?:
Anesthesia Problems			
Asthma/ Wheezing			
Bleeding Problems / Anemia			
Cancer (Type)			
Diabetes			
Emphysema/ COPD			
Heart Attack/ MI			
Heart Disease/ Heart Murmurs			
High Blood Pressure			
Stroke			
Thyroid Problems			
Other			

Indicate the current state of your relatives:

	ALIVE	DECEASED	CAUSE OF DEATH
MOTHER			
FATHER			
SIBLING			
SIBLING			

REVIEW OF SYSTEMS: Please check all that apply to you

GENERAL:
- ☐ fatigue
- ☐ weight change
- ☐ fever
- ☐ night sweats
- ☐ other: _____

RESPIRATORY:
- ☐ shortness of breath
- ☐ coughing up blood
- ☐ apnea w/ CPAP
- ☐ other: _____

MUSCULOSKELETAL:
- ☐ muscle pain
- ☐ other: _____

NEUROLOGICAL:
- ☐ tremor
- ☐ chronic facial pain
- ☐ weakness of face
- ☐ difficulty with speech
- ☐ other: _____

HEMATOLOGIC/ LYMPHATIC:
- ☐ easy bleeding or bruising
- ☐ other: _____

SKIN:
- ☐ easy bruising
- ☐ rash
- ☐ itching
- ☐ other: _____

CARDIOVASCULAR:
- ☐ chest pain
- ☐ palpitations
- ☐ murmur
- ☐ other: _____

GASTROINTESTINAL:
- ☐ heartburn or indigestion
- ☐ none of the above

GENITOURINARY:
- ☐ incontinence
- ☐ none of the above

PSYCHIATRIC:
- ☐ depression
- ☐ none of the above

ENDOCRINE:
- ☐ heat or cold intolerances
- ☐ other: _____

HEALTH ENT:

Eyes
- ☐ blurred vision
- ☐ double vision
- ☐ wearing glasses/contacts
- ☐ glaucoma
- ☐ other: _____

Ears
- ☐ change in hearing
- ☐ ringing in ear
- ☐ ear drainage
- ☐ hearing aids
- ☐ other: _____

Nose
- ☐ runny nose
- ☐ nasal obstruction/stuffiness
- ☐ bleeding
- ☐ sense of smell
- ☐ other: _____

Mouth
- ☐ mouth pain
- ☐ change in taste
- ☐ other: _____

Throat
- ☐ difficulty swallowing
- ☐ cough
- ☐ snoring
- ☐ sore throat
- ☐ change in voice
- ☐ other: _____

Allergy/Immune
- ☐ known environmental allergens
- ☐ known food allergies
- ☐ immune suppressed (HIV, Chemo)
- ☐ other:

accent
Physician Specialists

Medication, Pharmacy and Allergy Information

Name: _____ Date of Birth: _____ Date: _____

Pharmacy Name: _____ Pharmacy Number: _____

	Medication	Dose	How Often	Reason Why
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

	Allergy	Reaction
1		
2		
3		
4		
5		
6		
7		

accent

Physician Specialists

Authorization to Release Insurance and Medical Information

Patient Name: _____

Date of Birth: _____ Sex: M F

Mailing Address: _____ Apt. #:_____

City: _____ State: _____ Zip: _____

Best Phone #: _____ Cell Phone: _____

Parent/Guardian Name: _____

Date of Birth: _____

Mailing Address: _____ Apt. #:_____

City: _____ State: _____ Zip: _____

E-mail address: _____

Primary Care Physician: _____ Referred By: _____

Insurance Information

Primary Insurance: _____ Policy ID#_____

Policy Holder's Name: _____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Policy ID#_____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**:_____

I authorize Accent Physician Specialists to provide the treatment deemed necessary to care for the above named patient. I authorize the release of medical records and information to or from any medical practice or insurance plan concerning the diagnosis, treatment, and determination of care.

_____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

As a courtesy, Accent Physician Specialists, P.A. will file my insurance claim. Insurance payment for services and treatment are directed to Accent Physician Specialists, P.A. I understand that payment for services rendered and supplies provided is ultimately my responsibility and payment is due when billed, whether or not my insurance company had paid.

I hereby authorize the insurance carrier with whom I have a policy to pay benefits directly to Accent Physician Specialists, P.A. for rendered services. I agree to pay all charges that are not paid in full by my assigned insurance. In the event that I default on payment of my account, I agree to be held responsible for all fees, which could be 40% of the total amount due as well as the interest accrued on the amount in default, court costs and reasonable attorney fees.

I have received, read and understood the Accent Physician Specialists, P.A. Assignment of Benefits and Financial Responsibility statement above._____ (Please Initial)

H.I.P.A.A. Notice of Privacy Practices

I have received, read and understood the Accent Physician Specialists, P.A. H.I.P.A.A. Notice of Privacy page._____ (Please Initial)

Notice of Release of Information

In case of emergency, please list any parties you authorize access to health information. Understand that *only* the parties listed below are authorized to receive knowledge of your treatment, medications, appointments or surgery. This list may be revoked at anytime by notifying Accent Physician Specialists, P.A. in writing.

Name	Relationship	Phone Number

Please list the person(s) that you give consent and/or authorize to bring your minor child to his/her appointment(s) at Accent Physician Specialists. This includes them being able to sign for your minor child to receive treatment. This does **NOT** include surgery consent forms. **A parent or court appointed legal guardian MUST be present at the pre-op appointment to sign surgical consent forms.**

Name	Relationship	Phone Number

_____ _____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

accent

Physician Specialists

Ear, Nose & Throat
- Jeffrey Phillips, MD
- Brian Kerr, MD
- Daniel J. Hall, MD, FACS
- Alex Rafanan, PA-C

Endocrinology
- Sandra Werbel, MD
- Sadaf Jeelani, MD
- Colleen Digman, MD
- Manivel Eswaran, MD
- Renee Berens, P.A.-C
- Tamara Wright, P.A.-C

Facial Plastic Surgery
- Daniel J. Hall, MD, FACS

Audiology
- Ryan Baker, Au.D
- Diana Guercio, Au.D
- Steven Petrakis, Au.D
- Elizabeth Tobener, Au.D

Aesthetics
- Esther Strockbine, DNP

Thyroid Disorders
Otology
Hearing & Balance Disorders
Nose & Sinus Care
Laryngeal
Voice & Swallowing Disorders
Facial Plastic Surgery
Diabetes Management
Audiology
Head & Neck Surgical Oncology
ENT Allergy
Aesthetics

4340 Newberry Road, Suite 301
Gainesville, Florida 32607
Phone: (352)372-9414
Fax: (352)271-5393
accentmd.com

Patient Name: _____ **Date:** _____
(Print your name)

D.O.B: _____

As of October 1, 2011 we are required to get the following information from all of our patients. This requirement was implemented by the **Federal Government** for all EMR (Electronic Medical Record) users.

Please take a moment to answer the following questions. Place a circle around the answer in the shaded box that best fits the patient. Please give (1) answer for each column.

Thank you in advance for your cooperation in this matter.

Referral Source	*Race / Ethnicity*	*Language Preference*
PCP (Primary Physician)	White / Caucasian	English
Other MD	Black / African American	Spanish
Inter office referral	Latino	French
Friend	Asian	Creole
Family member	Other Pacific Islander	Other:
Internet or AccentMD.com	American Indian	
Yellow pages	More than 1 race	
News paper	Unreported / Refuse	

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you treatment, payment, and health care operations. You have the right to revoke this disclosure in writing, signed by you.

However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Authorization, in writing, at any time and all future disclosures will then cease

Signature_____ Date_____