ROBERT H. OLIVER, M.D., PLLC
Otolaryngology – Head And Neck Surgery
Otolaryngic Allergy

Chart #__________

PATIENT INFORMATION
Please Print, Complete Fully, And Return To The Front Desk

Circle One: Mr. Mrs. Ms. Miss. Dr. Child

Please Circle: Sex: Male Female Marital Status: S M Other Widowed

Patient Legal Name: ____ Date of Birth: ___/___/_____
First Middle Last

Address:____ Apt#____________________

City: _________________________________ State: _____________Zip:_______________

Home Phone: _________________________Work Phone:___________________________

Mobile Phone: ____________________Email Address: ______________________________

Name of Spouse/Parent/Legal Guardian:____

Authorization to Treat Minor Child:____

Relationship To Child:___________________________________

In Case Of An Emergency We Ask That You Please Provide A Person To Notify:

Name: _____________________________________Relationship: ____________________

Phone #: ________________________

Referring Physician: ____
Name Phone

Family Doctor: ____
Name Phone

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INSURANCE INFORMATION
Please Circle The Following Insurance Plan By Which You Are Covered

Chart #__________

First Insurance Name: Excellus MVP Aetna Cigna Fidelis

United HealthCare WellCare Essence Medicare Medicaid

Subscriber I.D. : _______________________________

Insurance in the name of : ___________________________________ DOB:___/_______/_______

Second Insurance Name: Excellus MVP Aetna Cigna Fidelis

UnitedHealthCare WellCare Essence Medicare Medicaid

Subscriber I.D. :_______________________________

Insurance in the name of:___________________________________ DOB:___/_______/_______

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AUTHORIZATIONS: PART I

I authorize the release of medical records necessary to process insurance claims.
I am *responsible* to pay for all services received regardless of insurance coverage.
I authorize payment of medical and surgical benefits to be made directly to Dr. Robert H. Oliver M.D.
I authorize the release of correspondence and/or medical records to other providers involved in my care.
I authorize any holder of medical information about me to release records to Dr. Robert H. Oliver M.D.

Patient Signature:____Date:______/______/________

AUTHORIZATIONS: PART II

HIPPA PRIVACY NOTICE

This practice is obligated under HIPPA to protect the privacy of your protected health information (PHI) and provide you with a notice of it's privacy practice.

ACKNOWLEDGMENT OF RECIPT: I acknowledge that I have reviewed a copy of the Practice's Privacy Notice. This notice describes the use of my healthcare information, discloses my protected health information and certain restrictions on the use of my health care information. I understand the Practice's Privacy Notice and it's effective date of January 1st 2009.

Patients Name:____ Today's Date :____/_____/_______

Patient Signature:_______________________________________

Release of Medical information to the following individuals:

Name:_______________________________ Relationship: _________________________

Name:_______________________________ Relationship: _________________________

Name: _______________________________ Relationship: _________________________

Name: _______________________________ Relationship: _________________________

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Patient Questionnaire

What is the reason for your visit today? ____

____

How long have you had this problem? ______________ **days/weeks/months/years**

Please List:
Allergies to Medications/Food/Latex: ____

____

____

Current Medications (Name, Dosage, Frequency):

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

Past Medical History: **Past Surgical History:**

____________________________ ____________________________ Date: / /

____________________________ ____________________________ Date: / /

____________________________ ____________________________ Date: / /

____________________________ ____________________________ Date: / /

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Family History

Has anyone in your **family** (mother, father, siblings, grandparents) had:

❐ Anesthesia Problems	❐ Heart Disease	❐ Tuberculosis
❐ Anemia	❐ Hereditary Disease	❐ HIV (Aids)
❐ Arthritis	❐ High Blood Pressure	❐ Thyroid Problems
❐ Asthma	❐ Kidney Disease	❐ Diabetes
❐ Bleeding Disorder	❐ Mental Illness	❐ Stroke

Cancer (type): ___________________________ Other: _______________________________

Patient's Social History

Do You:
Use Tobacco (circle: Cigarettes/Cigars/Pipe/Snuff/Chew)
How Much Daily: ___________(packs) For how many years:__________ Quit Date: ___/___/_______
Do You:
Use Alcohol (circle: Beer/Wine/Liquor)
How Often:______________________ per day/month
Do You:
Use Drugs (circle: YES NO)
How Often:_________________________per day/month

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Patient's General Overall Health Review Part II

Please check all that apply to YOU: Chart#___________

General:
- ❒ Fever
- ❒ Chills
- ❒ Weight Loss
- ❒ Night Sweats
- ❒ Diabetes

Ears:
- ❒ Hearing Loss
- ❒ Pain
- ❒ Ringing
- ❒ Dizziness
- ❒ Frequent Infection

Nose:
- ❒ Bleeding
- ❒ Congestion
- ❒ Post-Nasal Drip
- ❒ Loss of Smell/Taste
- ❒ Injury

Throat:
- ❒ Frequent Sore Throat
- ❒ Hoarseness
- ❒ Difficulty Swallowing
- ❒ Pain

Eyes:
- ❒ Vision Change
- ❒ Cataracts
- ❒ Glaucoma

Heart:
- ❒ Chest Pain
- ❒ Valve Repair
- ❒ Pacemaker/Defibrillator
- ❒ Heart Murmur

Lungs:
- ❒ Wheezing
- ❒ Shortness of Breath
- ❒ Chronic Cough
- ❒ Bronchitis
- ❒ Pneumonia

GI:
- ❒ Heart Burn
- ❒ Stomach Ulcers
- ❒ Diarrhea
- ❒ Nausea
- ❒ Vomiting
- ❒ Liver Problems

GU:
- ❒ Painful/burning During urination
- ❒ Kidney Stones
- ❒ Blood in Urine

Muscle:
- ❒ Arthritis
- ❒ Weakness in Limbs
- ❒ Tingling Sensation
- ❒ Back Pain
- ❒ TMJ/Jaw

Neuro/Psych:
- ❒ Depression/Anxiety/Panic Attack
- ❒ Headaches
- ❒ Numbness

Endocrine:
- ❒ Menopause
- ❒ Pregnancy
- ❒ Hormone Replacement
- ❒ Diabetes

Blood:
- ❒ Excessive Bleeding
- ❒ Blood Clots
- ❒ Easy Bruising
- ❒ Hemophilia
- ❒ HIV

Allergy:
- ❒ Itchy Eyes
- ❒ Runny Nose
- ❒ Hives
- ❒ Previous Allergy Testing

Cancer (Type):_________________

Other:_________________________

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Please Circle YES OR NO For the Following Questions:

May we leave a message on your home phone answering machine?	**Yes**	**No**
May we call or leave a message at your place of employment?	**Yes**	**No**
May we discuss your Medical Condition with a selected family member?	**Yes**	**No**

If Yes, With Whom do you give your Permission: ______________________________________

Relationship to Patient: __ Spouse ___ Child ___ Partner ___Other

Date: _______/_________/_________

Reviewed By: Dr. ____________________________________ Date:____/____/____

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To Our Valued Patients

a note about insurance

We urge our patients to review their insurance policies and be aware of their coverage and associated responsibilities.

In response to the increasing cost of healthcare, many employers have adopted high deductible plans requiring its members to a pay a large out of pocket sum of money before any insurance coverage begins. Other deductible plans may require a percentage of the payment due or a copay for services rendered.

Many of our patients now belong to high deductible plans which require paying a percentage of the total or the entire amount for services which may have previously been covered. Depending on whether the service performed is considered screening or diagnostic, the cost of the visit may be higher than anticipated.

Dr. Oliver requests ***payment whether it is a copay or deductible for all office visits at the time of service and all procedures done at the hospital within 30 days after receipt of statement.***

Thank you for your understanding

Patient initials__________

Date: _____/_____/_______

1295 Portland Avenue, Suite 24

Rochester, New York 14621

585-342-2080

Fax 585-301-4037