2750 Laurel Street, Suite 203
Columbia, SC 29204

One Wellness Boulevard, Suite 101
Irmo, SC 29063

Specializing In The Medical and Surgical Treatment of the Ears, Nose and Throat

Benjamin D. Paysinger, Jr., M.D., F.A.C.S.
Board Certified Otolaryngologist

Tab E. Thompson M.D., M.B.A., F.A.C.S.
Board Certified Otolaryngologist

Anna Lee Bouknight, M.D.
Board Certified Otolaryngologist

Hope Lanter, Au.D., CCC-A,FAA
Doctor of Audiology

Welcome to Palmetto ENT Consultants. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

To achieve this goal, there are several detailed patient information forms that must be completed *before the scheduled appointment* to allow us to serve you better.

These forms must be completed before the appointment.

The average time required to complete the forms is 45 minutes. For your convenience, this task may be accomplished by downloading the forms from our website at www.palmettoentconsultants.com. The forms may be accessed from the Patient Resources page or from sidebar locations throughout the website. Patients who do not have access to the website may request a copy by mail or e-mail before the appointment. **If you do not complete your paperwork before your visit, you will need to arrive 45 minutes before your scheduled appointment.** Failure to arrive 45 minutes before your appointment to complete the paperwork will cause your appointment to be rescheduled. We have found that at-home completion of the forms is best, allowing easier access to important health records and information.

Patients arriving **without completed forms** or later than **15 minutes** will be rescheduled as a courtesy to the staff and other patients. Please bring the following:

- Registration forms
- All health insurance cards (needed for every appointment)
- Photo identification

Insurance companies legally require us to collect all co-payments and deductibles **at the time of service.** Past due balances must also be resolved. We accept cash, check or credit card. If your insurance company requires a referral or authorization number for you to see a specialist, please contact your primary care physician for the necessary referral or authorization.

Appointments can be scheduled or rescheduled by calling 803-256-7076. We ask that you provide at least 24 hour notice for appointment cancellations. Please do not use the website Contact Form for general office business.

Patient emergencies may occasionally arise, causing delays in the schedule. We will keep you informed and give you the option to wait or reschedule.

Thank you for your cooperation and understanding as we strive to improve our efficiency and patient service.

Phone: 803-256-7076

Web: palmettoentconsultants.com
E-mail: Info@palmettoentconsultants.com

Fax: 803-256-0961

Benjamin Paysinger, M.D. **Tab Thompson, M.D.** **Anna Bouknight, M.D.**

Today's Date: ____________________ Patient's SSN: ________-________-________ Chart # ____________

Patient's Name: ____
First MI Last

DOB: ________/________/________ Age:________ Gender:__________ Race: ______________ Hispanic: Y N N/A

Street Address: ____ Apt/Unit#: ______________

City: ______________________________ State: ____________ Zip: ______________ Student: Yes / No

Marital Status: ______________ Employed: Full / Part / Not Employer: ______________________________

Home Phone: (_______)______________ Cell Phone: (_______)______________ Work Phone: (_______)____________

Written Contact Preference: Postal Mail / Email Email: ____

Primary Insurance: ______________________________ Secondary Insurance: ______________________________

Referred by (Physician,Friend,Media): __________________________ Primary Care Physician: ____________________

AUTHORIZATION STATEMENT: I HEREBY AUTHORIZE PAYMENT OF MY MEDICAL INSURANCE BENEFITS TO THE PHYSICIANS OF PALMETTO ENT CONSULTANTS, P.A. I AUTHORIZE THE PHYSICIANS TO RELEASE ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO AUTHORIZE MY MEDICAL RECORDS TO BE RELEASED TO ANOTHER PHYSICIAN WHO MAY ASSIST IN MY CARE. I UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES/FEES NOT COVERED BY MY INSURANCE CARRIER. I HAVE READ AND CERTIFY THAT ALL THE PROVIDED INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

Patient/ Guarantor Signature:____

INSURANCE **Complete this section ONLY if you are insured by your spouse OR are a minor insured by parents**

*****The parent accompanying the child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.*****

PRIMARY

Insurance Company______________________________ **Insured is: Spouse___Mother___Father____Other____**

ID#______________________________ **Group#**______________________________

Last Name:______________________________ First Name:________________________ Initial:________

SSN:________________________ Birth Date:_______/_______/_______ Home Phone:(_____)______________

Address if different from patient:____

City:________________________ State:________ Zip______________ Cell:(______)______________

Employer:______________________________ Work Phone:(______)______________

SECONDARY

Insurance Company______________________________ **Insured is: Spouse___Mother___Father____Other____**

ID#______________________________ **Group#**______________________________

Last Name:______________________________ First Name:________________________ Initial:________

SSN:________________________ Birth Date:_______/_______/_______ Home Phone:(_____)______________

Address if different from patient:____

City:________________________ State:________ Zip______________ Cell:(______)______________

Employer:______________________________ Work Phone:(______)______________

Benjamin Paysinger, M.D. **Tab Thompson, M.D.** **Anna Bouknight, M.D.**

NAME:______________________________ DOB:______________ AGE:________ GENDER:______ DATE:______________

HISTORY OF PRESENT ILLNESS

Name the major problem for which you are seeking medical care: ____

____

Describe the symptoms in detail: ____

____

____

How long have you had these symptoms? ____

What makes the symptoms better or worse? ____

Rate the severity of today's symptoms on a 1 – 10 scale (10= worst): ______________________________

List any treatments or operations you have had for these symptoms: ______________________________

____

List any diagnostic testing (CT, MRI's) you have had for these symptoms: ______________________________

____

List any other ENT physicians you have consulted for these symptoms: ______________________________

SURGICAL HISTORY (list below):

Surgery	Approx. Date	Surgery	Approx. Date

FAMILY HISTORY (mark all that apply):

Condition	Relationship to You	Condition	Relationship to You
Heart Disease/Attack		High Blood Pressure	
Blocked Arteries		Diabetes	
Stroke		Hearing Loss	
Sickle Cell Trait		Thyroid Problems	
Bleeding Problem		Allergies	
Cancer		Asthma	
Anesthesia Complications		Other:	

SOCIAL HISTORY (check all that apply):

Tobacco Use:	Never	Former	Current Some Days	Current Every Day	Heavy Smoker	Light Smoker	
Cigarettes							
Cigars							
Chewing Tobacco							
Dipping Tobacco							

Alcohol Use:	Social	Occasional	Light	Heavy
Beer				
Wine				
Liquor				

[ ] UNKNOWN TOBACCO USE

[ ] NO ALCOHOL USE

Current Occupation: ______________________________

Are you pregnant? [ ] Yes [ ] No [ ] N/A

Height: ________________ **Weight:** ________________

Benjamin D. Paysinger Jr., M.D. **Tab E. Thompson, M.D.** **Anna L. Bouknight, M.D.**

CHART #:________________

Name:______________________________ **DOB:**______________**AGE:**_____**GENDER:**_____ **DATE:**______________

REVIEW OF SYSTEMS

Check **YES** for those symptoms which apply to YOU and **NO** for those that do not apply.

CONSTITUTIONAL	YES	NO
Fatigue	☐	☐
Fever	☐	☐
Weakness	☐	☐
Weight Loss	☐	☐
Daytime Drowsiness	☐	☐
HEAD		
Dizziness	☐	☐
Head Injury	☐	☐
Headaches	☐	☐
Facial Pain	☐	☐
EYES		
Itchy Eyes	☐	☐
Discharge	☐	☐
Excessive Tearing	☐	☐
Eye Pain	☐	☐
Vision Change	☐	☐
ENT:		
NOSE		
Discharge	☐	☐
Hay Fever	☐	☐
Infections	☐	☐
Nasal Obstruction	☐	☐
Nosebleeds	☐	☐
Sinus Infections	☐	☐
Post Nasal Drip	☐	☐
Nasal Fracture	☐	☐
MOUTH		
Tongue Burning	☐	☐
Mouth Lesion	☐	☐
EARS		
Discharge	☐	☐
Dizziness	☐	☐
Hearing Aid	☐	☐
Infections	☐	☐
Ringing in Ears	☐	☐
Hearing Loss	☐	☐
Ear Pain	☐	☐

THROAT/NECK	YES	NO
Frequent Sore Throats	☐	☐
Lumps	☐	☐
Tenderness	☐	☐
Tonsils Enlarged	☐	☐
Voice Changes	☐	☐
Speech Disorders	☐	☐
Hoarseness	☐	☐
RESPIRATORY		
Asthma	☐	☐
Cough	☐	☐
Wheezing	☐	☐
Bronchitis	☐	☐
Coughing Blood	☐	☐
Short of Breath	☐	☐
CARDIOVASCULAR		
Chest Pain	☐	☐
Palpitations	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
History of Heart Attack	☐	☐
Recent EKG	☐	☐
GASTROINTESTINAL		
Abdominal Pain	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Swallowing Problem	☐	☐
Vomiting	☐	☐
Reflux	☐	☐
MUSCULOSKELETAL		
Arthritis	☐	☐
Joint Pain	☐	☐
Muscle Stiffness	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Disorientation	☐	☐
Memory Loss	☐	☐
Psychiatric Disorders	☐	☐
SKIN		
Eczema	☐	☐
Itching	☐	☐
Bruise Easily	☐	☐
Hives	☐	☐
Mole Increased Size	☐	☐
NEUROLOGICAL		
Loss of Consciousness	☐	☐
Numbness	☐	☐
Strokes	☐	☐
Tremors	☐	☐
Unsteady Gait	☐	☐
ENDOCRINE		
Cold Intolerance	☐	☐
Goiter	☐	☐
Neck Pain	☐	☐
Sweats	☐	☐
Thyroid Trouble	☐	☐
HEMATOLOGIC/LYMPH		
Anemia	☐	☐
Blood clots	☐	☐
Swollen Glands	☐	☐
ALLERGIC/IMMUNOLOGIC		
Coughing	☐	☐
Itchy Nose	☐	☐
Recurrent Infections	☐	☐
Sneezing	☐	☐
Stuffy Nose	☐	☐
Watery Eyes	☐	☐

PAST MEDICAL HISTORY

Check **YES** for those illnesses that apply to YOU and **NO** for those that do not apply.

	YES	NO
Anemia	☐	☐
Asthma	☐	☐
Coronary Artery Disease	☐	☐
Cancer (explain below)	☐	☐
HIV	☐	☐
HPV	☐	☐
Mental Health Problem	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

	YES	NO
Angioplasty/Stents	☐	☐
Atrial Fibrillation	☐	☐
Congestive Heart Failure	☐	☐
Diabetes	☐	☐
Hepatitis (A,B or C)	☐	☐
Hypertension	☐	☐
Mitral Valve Prolapse	☐	☐
Sickle Cell	☐	☐
Surgical Complication	☐	☐
Thyroid Nodule	☐	☐

	YES	NO
Arthritis	☐	☐
CABG	☐	☐
COPD	☐	☐
GERD	☐	☐
Hiatal Hernia	☐	☐
MI (Heart Attack)	☐	☐
Pacemaker	☐	☐
Sleep Apnea	☐	☐
TB (Tuberculosis)	☐	☐
Other (explain below)	☐	☐

Have you ever had cancer?__________ If yes, list site(s), treatment(s) and approximate date(s):

____

____

____

____

List any medical problems not specified above:____

____**Reviewed by:**________________

Chart # ________________

NAME: ____________________ DOB: ________ AGE: ____ GENDER: ____ DATE: ________________

CURRENT MEDICATION FORM

Pharmacy Name: ____________________ **Referring Physician:** ____________________

Pharmacy Phone # (_____)______________ **Primary Care Physician:** ____________________

DRUG ALLERGIES

	YES	NO
Penicillin	☐	☐
Sulfa	☐	☐
"Mycins"	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Demerol	☐	☐
Latex	☐	☐
Other Drug Allergies	☐	☐

LIST Other: ____________________

____

____

____

BLOOD THINNERS

	YES	NO
Coumadin	☐	☐
Plavix	☐	☐
Aspirin	☐	☐
Non-Steroidal (Ibuprofen, Aleve)	☐	☐
Other Blood Thinners	☐	☐

LIST Other: ____________________

____

____

____

☐ I have a bleeding disorder.

LIST <u>ALL</u> OTHER MEDICINES YOU ARE CURRENTLY TAKING to include prescriptions and over-the-counter medications (examples: antihistamines, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION/ DOSAGE	DIRECTIONS: How often taken	REASON	PRESCRIBING PHYSICIAN

☐ **I consent to ALL electronic prescription transactions.** Reviewed by: ____________________

Benjamin Paysinger, M.D. Tab Thompson, M.D. Anna Bouknight, M.D.

ePrescribing Consent:

Patient Name:______________________________ **Date of Birth:**________________

Palmetto ENT Consultants, P.A. has implemented ePrescribing in each of our offices.

- ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.
- ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- ePrescribing software also lets your doctor see important information—like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.
  (Note: Refill requests should be made directly to your pharmacy)

PREFERRED PHARMACY INFORMATION:

Name of Pharmacy:____
Address:__________________________________ Zip Code:__________
Phone:__________________________Fax:______________________

Patient Consent:

I agree that Palmetto ENT Consultants, P.A. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. **This consent is valid for two years. Please notify us if your pharmacy information should change.**

Patient Signature:______________________________ Date:______________

Benjamin Paysinger, M.D. **Tab Thompson, M.D.** **Anna Bouknight, M.D.**

Acknowledgment of Reciept of Privacy Notice

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that Palmetto ENT Consultants, P.A. provide you with a notice regarding Privacy of Personal Health Information. The "Notice" explains how your information may be used and disclosed as permitted under federal and state law.

Please sign below acknowledging that you have been presented with a copy of Palmetto ENT Consultants "Notice of Privacy Policies".

Signed: ____ **Date:** ____________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: ______________________ Witnessed by: ______________________________

Financial Policy

HMO or PPO Insurance: You must present a current insurance card at every visit. All HMO plans will require a current referral from the PCP prior to you being seen. We are legally required by insurance companies to collect all co-payments and deductibles at the time of service. Past due balances must also be resolved. We accept cash, check or credit card.

Medicare Insurance: You must have a current Medicare card, and be prepared to pay your deductible and/or 20% of the allowed charges.

Non-Contracted Private Insurance: If we do not participate with your insurance company, you will be responsible for full payment at the time of service.

No Insurance/Self Pay: Payment is expected in full at the time services are rendered.

For your convenience we accept Cash, Check or Credit Card. There will be a $30.00 charge for returned checks.
Please remember that regardless of your insurance coverage, you are responsible for your bill. If your insurance carrier has not paid your claim in full within 60 days you will be contacted regarding payment.
All outstanding balances must be paid within 90 days of the date of service unless a financial agreement has been made.
Assignment of Insurance Benefits: I hereby assign benefits to be paid, on my behalf, to Palmetto ENT Consultants, P.A. for services rendered to me. I understand and agree to be financially responsible for charges not paid within a reasonable period of time by the insurance company, and certify that the information given with regard to my insurance coverage is correct.
I have acknowleged and read the above.

Signed: ____ **Date:**____________________

Relationship to Patient: ______________________

Guarantor Information **Relationship to patient:** ___ **Mother** ___ **Father** ___ **Other (please explain)**__________

Last Name: ______________________________ **First Name:** ______________________________

SSN: _________-_______-__________ **DOB:** _______/________/________ **Phone #:** ____________________

Address: ______________________________ **City:** ________________ **State:** ______ **Zip:** ______