

ENT Associates Of Savannah

5201 Frederick Street
Savannah, GA 31405
(912) 351-3030

PATIENT INFORMATION							
NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)							
NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED			GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT
CITY, STATE ZIP	PHONE		DEDUCTIBLE
RELATIONSHIP TO PATIENT			EFFECTIVE DATE
			EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED			GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT
CITY, STATE ZIP	PHONE		DEDUCTIBLE
RELATIONSHIP TO PATIENT			EFFECTIVE DATE
			EXPIRATION DATE

I authorize ENT Associates of Savannah, P.C. to release medical records and demographic information pertinent to processing of my medical claims.

SIGNATURE OF PATIENT/GUARDIAN

DATE

	Patient Name:
HISTORY	PROGRESS AND DISCHARGE NOTES
Present Illness:	Pre-Op Test Reviewed () Yes () No () NA
	Comments:
See Attached Consult Form:	
	OPERATIVE REPORT
	Post-Op Dx:
Past Medical / Surgical History	Procedure:
	Findings
Family / Social History:	
Medications:	EBL: Anesthesia:
	Packing:
	Complications: Pathology Sent
	Condition: Culture Sent
	Dictated: Yes No
Allergies:	
Review of Systems	
PHYSICAL EXAM	PROGRESS NOTES
Height: Weight:	D/C Home when meets D/C criteria
General Appearance	
Mental Status	
HEENT	
Heart:	
Lung:	
Other:	
	DISCHARGE
Impression:	Discharge Instructions: Standing
	Other:
○ Surgical Consent Discussed with Patient/ Guardian	Medications and dosages
Plan	
Date: Time:	Follow-Up Appointments

Signed: _____

Date: _____

HISTORY AND PHYSICAL

Use and Disclosure Of Protected Health Information Patient Authorization Form

I authorize Ear, Nose & Throat Associates of Savannah, P.C. to disclose and/or release my identifiable health information about me to:

** Family or Friend(s)*

Name	Health Information	Billing Information	Medical Records	Date Revoked/Initials

I authorize the following individuals to make decisions on my behalf concerning:

** Family or Guardian*

Name	Medical Treatment	Financial Matters	Medical Records	Date Revoked/Initials

I request Ear, Nose & Throat Associates of Savannah, P.C. to release Protected Health Information (PHI) or Medical Records to the following:

** Your primary care physician, etc.*

Name	Address	PHI/Medical Records	Date Authorized

I have the right to revoke this authorization at any time. This authorization remains in effect unless it has been revoked.

Signed by:

Signature of Patient or Legal Guardian

Relationship to Patient

Signature of Patient or Legal Guardian

Relationship to Patient