Patient Medical History

Confidential

Patient Name____ Today's Date____________

Date of Birth_____________________Age________SSN_____________________________

Height___________ Weight__________ Emergency Contact ___________________________

E-mail Address:____

Referring Doctor____________________ Family Physician ____________________________

Chief Complaint ____

(Reason for today's visit)

Insurance Information

Primary Insurance __________________________ Policy/Group Number________________
Policy Holder ______________DOB___________ Relationship to Patient _______________
Secondary Insurance _________________________ Policy/Group Number ________________
Policy Holder ______________DOB___________ Relationship to Patient _______________

Current Medications **Dose** **Frequency**

____
____
____
____
____
____
____

Have you taken any aspirin, ibuprofen or arthritis medicine in the last two weeks?__________________
If so when?_____________________________ Do you bruise easily? ________________________

DRUG ALLERGIES:____

Medical Illnesses:

____
____
____
____

Hospitalizations **Date**

____
____
____

Surgical Procedures **Date**

____
____
____
____

Have you ever had problems with anesthesia? __Yes __No
If yes, describe:____

Release of Records

Who may have access to your medical records?

Name	**Relation**	**Contact Information**

Family History

Family Member	**Medical Illnesses**
Mother	
Grandparents (maternal)	
Father	
Grandparents (paternal)	
Sister(s) / Brother (s)	

Social History

Are you presently working or going to school full or part time? ______________________________

Employer / School: ____

Marital Status:_____________ Do you live alone? ________ Who lives with you?_________________

Do you have children?______ If yes, how many?____

Do you smoke? __Yes __No Cigars?__________ Pipe?__________ Chewing tobacco?_________

Cigarettes per day?_____________ How long have you been chewing or smoking _______________

Do you drink alcohol? __Yes __ No
Is it __Social __Heavy __Prior addiction?

Do you take or have you taken recreational drugs? __Yes __No __Prior addiction

Do you have any difficulty sleeping?
__Never __Often __Sometimes __Getting to sleep __Staying awake

Does anyone complain that you snore? __Yes __ No

Do you stop breathing at night? __Yes __No

Do you wake up tired in the morning? __Yes __ No

Do you fall asleep in the daytime? __Yes __No

Caffeine intake: ____ per day

Do you exercise? __ Yes __No Type/Frequency:_____________________________

Are you at risk for HIV? If yes, explain ____

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam ______
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_______
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray_____

Cardiovascular
__ Chest pain
Date of last EKG _______
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising
__ Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
____

Musculoskeletal
__ Broken bones
list:______________
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

Psychiatric
__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide / homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia
__ Other psychiatric problems
__ Under psychiatric care
__ Desiring psychiatric care

The above information is accurate to the best of my knowledge.

______________________________ ______________
Patient Signature *Date*

I have reviewed the above information with the patient.

______________________________ ______________
Boris Karanfilov, M.D. / Sumit Bapna, M.D. *Date*

Sumit Bapna, M.D.
5378 Avery Road
Dublin, Ohio 43016

Managed Care Insurance

Ohio Facial Plastics will submit insurance claims for medical/surgical services provided to patients with insurance coverage in a managed care plan (PPO, HMO, POS) that our office participates in. A copy of your insurance card must be presented to our office. Patients without an insurance card must pay at the time of service. Patients presenting valid cards with PPO, HMO and POS identification are required to pay their co-pay amount, if applicable, at the time of service. Managed care discounts will not be honored if the insurance card provided at the time of service does not indicate a plan that our office participates in. For patients in participating plans, charges for services rendered will be sent to your insurance company for direct reimbursement to our office. You will receive a statement if a balance representing your portion owed remains due after we receive payment from your insurance company. If you participate in an HMO or POS plan that requires authorization from your primary care physician, we require a referral or authorization number at the time of service in order to submit your insurance claim for payment. Without a referral or authorization from your primary care physician, your benefits may be reduced or denied entirely. HMO patients without referrals incurring medical services or seeking out-of-network services will be required to pay at the time of service.

Medicare and Medicaid Insurance

Ohio Facial Plastics accepts Medicare and Medicaid assignment. Copies of current Medicare and Medicaid cards are required. Medicaid cards with invalid dates will not be accepted and patient will be required to pay at the time of service. Our office will submit claims to Medicare, the Illinois Department of Public Aid and participating Medicare supplemental plans for reimbursement. Insurance payment will be issued to Ohio Facial Plastics. If a balance representing your co-insurance, deductible, or non-covered portion remains due after insurance payment is received, you will receive a statement indicating your portion owed. A 15% discount will be honored for non-covered services that are paid in full at the time of service.

Traditional Indemnity Insurance

For Patients with traditional indemnity coverage, our office will submit a claim to your insurance company for direct reimbursement to Ohio Sinus Institute. If a balance remains due after insurance payment is received, you will receive a statement indicating your portion owed.

Self-Pay

Patients without medical insurance are requested to pay at the time of service. If you cannot pay for medical services in full, you may consult with a member of our business office staff to arrange a payment plan. Payment plans remain an option for all patients regardless of insurance coverage. I understand the provisions of Ohio Facial Plastic's Billing Policy as they apply to me. I further understand that I am financially responsible for any charges not covered by my insurance plan and that full payment is due within 90 days of the date of the service(s). I understand that if my balance exceeds 90 days, credit and collection procedures will commence and a monthly interest charge at the rate of 1% of the outstanding balance will accrue on my account unless special financial arrangements are made in advance with the office staff.

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Date   Patient Name   Signature of Patient/Responsible Party

Assignment of Benefits and Records Release Form

Release of Records:

I hereby authorize Ohio Facial Plastics to provide diagnostic and treatment services to me. Ohio Facial Plastics has my permission to release any information needed for completion of their claims for payment from third party payers, including but not limited to: insurance companies, health maintenance organizations government agencies and their representatives. I permit release of information concerning dates of treatment, condition, diagnosis, procedures or surgeries to my personal physician, referring physician, and/or the referring facility or for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse, and/or psychiatric treatment.

Date Patient Name Signature of Patient/Responsible Party

Assignments of Benefits:

I acknowledge financial responsibility for all facility and physician(s) fees. I understand that the physician billing office will file my insurance claim if my physician/provider is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by the facility and physician/provider.

Date Patient Name Signature of Patient/Responsible Party

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Authorization for Medicare Patients Only

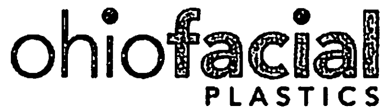
I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Ohio Facial Plastics for any services unfurnished to me by that physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.

In Medicare assigned cases the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon charge determination of the Medicare carrier.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown.

This authorization is in effect for my lifetime or until I choose to revoke it.

Date Signature of Medicare Beneficiary



Acknowledgement of Receipt of Privacy

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information. This is a summary of the more detailed information contained in out Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of our Notice of Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payers make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and find out how you felt about our service
- Disclose information to certain officials or organizations where we may, or are required to do so by law

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, and why my confidential health information may be used or shared. I acknowledge that Ohio Sinus Institute physicians and other Ohio Facial Plastics staff may use and share my confidential health information with others in order to arrange for payment of my bill and for issues that concern Ohio Sinus Institute operations and responsibilities.

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Date　　　Patient Name　　　Signature of Patient/Responsible Party

Signature of staff member delivering notice: ______________________________

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Attempt to Deliver Notice of Privacy Practices:

____

Patient Name　　　Date

However, delivery could not be made because:

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Signature of Practice Employee　　　Title　　　Date