

# Pappas Ear Clinic

## Patient Health History

Name

Age

Chief Complaint

Duration

### Past History

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> alcoholism           | <input type="checkbox"/> Down syndrome | <input type="checkbox"/> liver disease             | <input type="checkbox"/> stroke                |
| <input type="checkbox"/> alzheimer's          | <input type="checkbox"/> emphysema     | <input type="checkbox"/> migraine headaches        | <input type="checkbox"/> stroke (mini)         |
| <input type="checkbox"/> arthritis            | <input type="checkbox"/> fibromyalgia  | <input type="checkbox"/> MVP mitral valve prolapse | <input type="checkbox"/> thyroid disease       |
| <input type="checkbox"/> asthma               | <input type="checkbox"/> glaucoma      | <input type="checkbox"/> myasthenia gravis         | <input type="checkbox"/> tuberculosis          |
| <input type="checkbox"/> anemia               | <input type="checkbox"/> gout          | <input type="checkbox"/> pacemaker                 |  |
| <input type="checkbox"/> autoimmune disease   | <input type="checkbox"/> heart disease | <input type="checkbox"/> peptic ulcer disease      | <input type="checkbox"/> malignant hypothermia |
| <input type="checkbox"/> back problems        | <input type="checkbox"/> heart attack  | <input type="checkbox"/> prostate disease          | <input type="checkbox"/> pregnancy (current)   |
| <input type="checkbox"/> cancer               | <input type="checkbox"/> heart murmur  | <input type="checkbox"/> reflux                    | <input type="checkbox"/> renal failure         |
| <input type="checkbox"/> cleft lip            | <input type="checkbox"/> hemophilia    | <input type="checkbox"/> renal stones              | <input type="checkbox"/> multiple sclerosis    |
| <input type="checkbox"/> cleft palate         | <input type="checkbox"/> hepatitis     | <input type="checkbox"/> rheumatic fever           | <input type="checkbox"/> no medical issues     |
| <input type="checkbox"/> cleft palate and lip | <input type="checkbox"/> hepatitis A   | <input type="checkbox"/> seizure disorder          |  |
| <input type="checkbox"/> defibrillator        | <input type="checkbox"/> hepatitis B   | <input type="checkbox"/> sickle cell disease       |  |
| <input type="checkbox"/> depression           | <input type="checkbox"/> hepatitis C   | <input type="checkbox"/> sickle cell trait         |  |
| <input type="checkbox"/> diabetes insulin     | <input type="checkbox"/> HIV/AIDS      | <input type="checkbox"/> sleep apnea with CPAP     |  |
| <input type="checkbox"/> diabetes noninsulin  | <input type="checkbox"/> hypertension  | <input type="checkbox"/> sleep apnea               |  |

Cancer Type:

Additional Past History:

Prior Surgery

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> none           | <input type="checkbox"/> tonsillectomy | <input type="checkbox"/> hernia repair | <input type="checkbox"/> cancer surgery  |
| <input type="checkbox"/> ear tubes      | <input type="checkbox"/> adenoidectomy | <input type="checkbox"/> back surgery  | <input type="checkbox"/> plastic surgery |
| <input type="checkbox"/> ear surgery    | <input type="checkbox"/> appendectomy  | <input type="checkbox"/> oral surgery  |  |
| <input type="checkbox"/> cardiac        | <input type="checkbox"/> gallbladder   | <input type="checkbox"/> sinus surgery |  |
| <input type="checkbox"/> cardiac stents | <input type="checkbox"/> hysterectomy  | <input type="checkbox"/> brain surgery |  |

Additional Prior Surgery:

Birth History  
(children only)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Normal Birth    | <input type="checkbox"/> Complicated Delivery  | <input type="checkbox"/> Ventilator     |
| <input type="checkbox"/> Abnormal Birth  | <input type="checkbox"/> Complicated Pregnancy | <input type="checkbox"/> ICU            |
| <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Low APGAR             | <input type="checkbox"/> Elev Bilirubin |

MD sign:

_____	_____	_____
_____	_____	_____

- Family History
- hearing loss
  - bleeding disorder
  - heart disease
  - severe anesthesia reactions
  - brain tumors
  - hypertension
  - asthma
  - cancer
  - stroke
  - autoimmune disease
  - diabetes

Additional Family History:

- Social History  married  single  widowed  disabled  student

- Smoking History  nonsmoker  social smoker  chews tobacco  
 smoker  quit smoking  vaping

- Packs per day  <1  1  1-2  2  2-3  3 or more

smoking years  years quit

- Alcohol  yes  no  quit drinks per day  or drinks per week

- Occupational Status  employed  unemployed  housewife/husband  disabled  student

Occupation:

<u>Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Medications</u>	<u>Dose</u>	<u>Frequency</u>

- Allergies
- Penicillins
  - Erythromycin
  - Caine Drugs
  - Other: \_\_\_\_\_
  - Sulfa
  - Aminoglycocides
  - Aspirin
  - Other: \_\_\_\_\_
  - Cephalosporins
  - Codeine
  - Iodine
  - Other: \_\_\_\_\_
  - Cipro
  - Morphine
  - Anesthesia meds
  - Other: \_\_\_\_\_
  - Levaquin
  - Demerol
  - None

MD sign: \_\_\_\_\_

(Please check yes or no for each item)

**Cardiovascular:**

	yes	no
irregular pulse	___	___
palpitations	___	___
chest pain	___	___
valve disease	___	___
left arm pain	___	___

**Respiratory:**

bronchitis	___	___
pneumonia	___	___
chronic cough	___	___
shortness of breath	___	___
bloody sputum	___	___

**Eyes:**

loss of vision	___	___
dryness	___	___
cataracts	___	___
eye infections	___	___
eye injuries	___	___

**Genitourinary:**

blood in urine	___	___
incontinence	___	___
urinary infections	___	___
difficult / painful urine	___	___

**Endocrine:**

hormone problems	___	___
excessive thirst	___	___
excessive urination	___	___
increased appetite	___	___
change glove/shoe size	___	___

**Hematologic (blood):**

anemia	___	___
prior transfusion	___	___
bleeding tendency	___	___
enlarged glands	___	___

**Immunologic:**

nasal allergies	___	___
food allergies	___	___
autoimmune disorder	___	___

**ENT:**

	yes	no
nosebleeds	___	___
sore throats	___	___
hoarseness	___	___
difficult swallowing	___	___
nasal congestion/drainage	___	___

**Gastrointestinal:**

stomach pain	___	___
nausea / vomiting	___	___
diarrhea	___	___
hemorrhoids	___	___
liver disease	___	___

**Neurologic:**

headaches	___	___
seizures	___	___
fainting spells	___	___
double vision	___	___
memory difficulties	___	___

**Skin:**

rash	___	___
chronic itching	___	___
nail changes	___	___
breast lump / discharge	___	___

**Musculoskeletal:**

muscle weakness	___	___
joint pain	___	___
back pain	___	___
recent broken bones	___	___

**Constitutional:**

fever / chills	___	___
night sweats	___	___
fatigue	___	___
unexpected weight change	___	___

**Psychiatric:**

depression	___	___
anxiety attacks	___	___
memory loss / confusion	___	___

MD sign: \_\_\_\_\_

\_\_\_\_\_

## Patient Registration Form

Patient's Legal Name: \_\_\_\_\_

Referred By: \_\_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status (Circle): Minor   Single   Married   Widow(er)   Divorced   Separated

Patient's Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Patient's (or Parents) Email (for Appt. Reminders): \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Cellular Carrier (for Text Reminders): \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Spouse's Work Phone #: (\_\_\_\_) \_\_\_\_\_

**If Patient is a MINOR**, fill in responsible parent or guardian:

Mother's Name: \_\_\_\_\_ Mother's Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Father's Address: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Emergency Contact:** NOT living with you:

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

# Pappas Ear Clinic, P.C.

***Medical Record Release:***

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of PAPPAS EAR CLINIC, P.C. and/ or assisting in any reimbursement or medical benefits to which patient may be entitled. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to Pappas Ear Clinic, P.C. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

***Agreement to Pay:***

I the undersigned, accept the fee charge as a legal and lawful debt and agree to pay said fee, including and/ all collection agency fees (33.33%), attorney fees and/ or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

You agree, in order for us to service your account or collect monies you may owe, Pappas Ear Clinic and/ or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide us. Methods of contact may include using pre-recorded artificial voice messages and/ or use of automatic dialing device, as applicable.

I/ We have read this disclosure and agree that Pappas Ear Clinic, its employees and/ or agents may contact me/ us as described above.

**I AUTHORIZE TREATMENT BY PAPPAS EAR CLINIC, P.C. AND PERSONNEL.**

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

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**Responsible Party Signature**

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**Date**

Pappas Ear Clinic, P.C.  
**Patient Contact Information Sheet**

Patient Legal Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Any physician, staff, employee, or representative of Pappas Ear Clinic, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment, and payment:

Name	Relationship	Phone Number(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Pappas Ear Clinic, P.C. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may subject to redisclosure by the individual(s).

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**VERBAL INFORMATION ONLY**

## Pharmacy Information

Patient Name: \_\_\_\_\_

Date Birth: \_\_\_\_\_

The following information is needed for any prescriptions that may be written by the Pappas Ear Clinic, P.C.

Pharmacy Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pharmacy Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

# Cancellation/ Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/ cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

## Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call the Pappas Ear Clinic if you are unable to make an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

## How to Cancel Your Appointment:

To cancel appointments, please call (205)-251-7169. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

## Late Cancellations:

Late cancellations will be considered a **"no-show."**

## No-Show Policy:

A **"no-show"** is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of scheduled appointment will be recorded in the patient's chart as a "no-show." **A fee of \$25.00 will be billed to the patient's account.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Pappas Ear Clinic, P.C.

Otology and Otolaryngology  
Skull Base Surgery  
Ear Disorders of Adults and Children  
Facial Nerve Disorders Cochlear Implants

Dennis G. Pappas, M.D.  
Dennis G. Pappas, Jr., M.D.  
Lynn C. Carmichael, Au.D., CCC-A, F-AAA

2937 7th Ave South  
Birmingham, Al 35233

Phone: (205)-251-7169  
Fax: (205)-254-3013

In preparing your chart, there is certain information that must be obtained in order to provide a thorough visit with your doctor. **This packet contains directions and patient forms that need to be filled out completely and brought to our office** at the time of your visit. Present these forms along with **picture ID and insurance card** to our receptionist upon your arrival.

It is VERY IMPORTANT that you bring any medical records that may be pertinent to your visit with us. This should include hearing tests, ENG'S, VNG's, MRI's, and CT scans or other diagnostic studies performed elsewhere. We need to have films to review and a copy of the report on any MRI or CT scan you may have had performed. **If we do not have a copy of these to review at the time of your visit then this may cause a delay in any recommendations for treatment.**

If your insurance requires prior authorization from your primary care physician, please be certain that this authorization has been received by our office prior to your coming in. Otherwise, this will detain you from seeing the doctor in a timely manner. **Payment for co-pays, deductibles, or other treatment or medication not covered by your insurance company is expected prior to visit with the doctor, the day services are rendered.**

Our office hours are 7:30 A.M. to 4:00 P.M. Monday- Friday. IF YOU MUST CANCEL YOUR APPOINTMENT, we would appreciate 24 hours notice so that someone else can be given the opportunity to see the doctor. **THERE WILL BE A \$25.00 CHARGE IF WE DO NOT RECEIVE 24 HOUR NOTICE OF APPOINTMENT CANCELATION OR RESCHEDULE.**

**We ask that you refrain from wearing any perfume or cologne to your appointment in courtesy of other patients, as well as the doctor's and their staff.**

Thank you for allowing us to participate in your treatment needs.

- Pappas Ear Clinic, P.C.

## Driving Directions to Pappas Ear Clinic

### **Address**

2937 7th Ave South  
Birmingham, Al 35223  
205-2517169

#### ***From Gadsden/ Fort Payne/ North East Alabama***

Travel into Birmingham on I-59 South

Take Exit 126 A (Hwy 31 South/ 280 East) **DO NOT FOLLOW CARRAWAY BLVD.**

Finally, follow Step #1 at the bottom of the page.

#### ***From Huntsville/ Decatur/ North Alabama/ Nashville***

Travel into Birmingham on I-65 South then I-59 North (20 East following the signs to Atlanta)

Finally, follow Step#1 at the bottom of the page.

#### ***From Tuscaloosa/ Meridian/ West Alabama/ Mississippi***

Travel into Birmingham on I-59 North/ 20 East

Take Exit 126 A (Hwy 31 South/ 280 East) **DO NOT FOLLOW CARRAWAY BLVD.**

Finally, follow Step #1 at the bottom of the page.

#### ***From Montgomery/ Mobile/ Gulf Shores/ South Alabama***

Travel into Birmingham on I-65 North.

Finally, follow Step #2 at the bottom of the page.

#### ***From Dothan/ Enterprise/ South East Alabama/ North East Florida***

Take Hwy 231 North to Montgomery, then I-65 North to Birmingham.

Finally, follow Step #2 at the bottom of the page.

#### ***From Atlanta/ East Alabama/ West Georgia***

Travel into Birmingham on I-59 South/ 20 West.

Finally, follow Step #1 at the bottom of the page.

### **STEP #1**

Take Exit #126 A (Hwy 31 South/ 280 East) **DO NOT FOLLOW CARRAWAY BLVD.**

Go approximately 1-1.5 miles and exit right onto 8th Ave ( University Blvd). Turn LEFT onto 8th Ave South (also called University Blvd) at traffic light. Go 4 blocks, turn LEFT on 30th Street South, and we are the 4th building on your left. The Pappas Building is on the west corner of 7th Ave South and 30th Street South. Our office entrance is off 30th Street South/ the ENTIRE TOP FLOOR of the building.

### **STEP #2**

Take the University Boulevard Exit #259. Stay on University Blvd to 30th Street South. Turn LEFT on 30th Street South and we are the 4th building on your left. The Pappas Building is on the west corner of 7th Ave South and 30th Street South. Our office entrance is off 30th Street South/ the ENTIRE TOP FLOOR of the building.