PLEASE DO NOT DOUBLE-SIDE PRINT FORMS

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. **If a MRI/CT has been performed we must have the films/CDs to review and a copy of the reports at the time of your visit.** 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.

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

- Pappas Ear Clinic, P.C.

Pappas Ear Clinic, P.C.

Otology and Otoneurology
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.

Pappas Ear Clinic

Patient Health History

Name _____ Age _____

Chief Complaint _____

Duration _____

Past History

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

Cancer Type: _____

Additional Past History: _____

Prior Surgery

- [ ] none
- [ ] ear tubes
- [ ] ear surgery
- [ ] cardiac
- [ ] cardiac stents
- [ ] tonsillectomy
- [ ] adenoidectomy
- [ ] appendectomy
- [ ] gallbladder
- [ ] hysterectomy
- [ ] hernia repair
- [ ] back surgery
- [ ] oral surgery
- [ ] sinus surgery
- [ ] brain surgery
- [ ] cancer surgery
- [ ] plastic surgery

Additional Prior Surgery: _____

Birth History (children only)

- [ ] Normal Birth
- [ ] Abnormal Birth
- [ ] Premature Birth
- [ ] Complicated Delivery
- [ ] Complicated Pregnancy
- [ ] Low APGAR
- [ ] Ventilator
- [ ] ICU
- [ ] Elev Bilirubin

MD sign: _____ _____ _____

_____ _____ _____

Family History

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

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 ☐ studen

Occupation:

Medications	Dose	Frequency	Medications	Dose	Frequency

Allergies

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

MD sign: _____ _____ _____

_____ _____ _____

(Please check yes or no for each item)

	yes	no
Cardiovascular:		
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	___	___

	yes	no
ENT:		
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.

_____ _____

Responsible Party Signature **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**_____