Matthew E. Beuerlein, M.D.
Gregory J. Mulcahy, M.D.

2521 Glenn Hendren Drive, Suite 104 Liberty, Missouri 64068 **P** 816-781-1001 **F** 816-792-0408 **www.libertyhospital.org**

Comprehensive Health History

PATIENT FULL LEGAL NAME ______________________ **DATE OF BIRTH** ______________

Home Phone ______________ Cell Phone ______________ Occupation ______________

Marital Status ______________ Work Phone ______________ Employer ______________

Spouse's Legal Name ______________________ Total years of education completed ________

Number of children ________ At home ______________ Outside of home ______________

What current ear, nose or throat concerns do you have ? ______________________

FAMILY PHYSICIAN ______________________ **REFERRING PHYSICIAN** ______________________

LEARNING PREFERENCES

What is your learning preference ☐ verbal ☐ written

Do you have any learning barriers? ☐ yes ☐ no

What are those barriers? ______________________

PEDIATRIC *(under 18 years old only)*

Mother's Name ______________________ Phone ______________________

Father's Name ______________________ Phone ______________________

How long have you lived in this area? ______________

WELLNESS

Have you ever, or do you:

SMOKE ☐ yes ☐ no Packs per day ________ Year quit ________ Any smokers in the home? ☐ yes ☐ no

SMOKELESS TOBACCO ☐ yes ☐ no ☐ quit How much? ________ Year quit ________

DRINK ALCOHOL ☐ yes ☐ no What forms? ________ Quantity ________ Frequency ________

ILLICIT DRUGS ☐ yes ☐ no What forms? ________ Quantity ________ Frequency ________

ALLERGIES (medication & food) ☐ No known ***medication*** allergies ☐ No known ***food*** allergies

List all medication and food allergies, please identify reaction ______________________

____

Do you have seasonal allergies? ☐ yes ☐ no

Are you allergic to latex or latex based products? ☐ yes ☐ no ☐ unknown

Pharmacy Name and Number ______________________

MEDICATIONS

Medication	Dose	How often do you take	Medication	Dose	How often do you take

PATIENT FULL LEGAL NAME ______________________ DATE OF BIRTH ______________

FAMILY HISTORY

Are your parents living? Mother ☐ yes ☐ no Father ☐ yes ☐ no Cause of death? ______________

Please list any health conditions/serious illnesses that your mother, father, sister(s) or brother(s) have or have been told they have had in the past (i.e. diabetes, heart condition, high blood pressure, stroke, high cholesterol, cancer, thyroid, etc.)

Father ______________

Mother ______________

Sister(s) ______________

Brother(s) ______________

PAST MEDICAL HISTORY

- ☐ AIDS or HIV positive status
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Cancer (please list below)
- ☐ Chronic bronchitis or emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart rhythm problems
- ☐ Hepatitis or liver disease
- ☐ High cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Myocardial Infarction (heart attack)
- ☐ Pneumonia
- ☐ Spine Problems
- ☐ Stroke
- ☐ Urinary tract disease

Other ______________

PAST SURGERIES OR TRAUMA HISTORY

- ☐ Anesthesia difficulties
- ☐ Appendectomy
- ☐ Cholecystectomy (gall bladder)
- ☐ Coronary artery bypass grafting
- ☐ Coronary artery stenting
- ☐ Ear or mastoid surgery
- ☐ Excessive bleeding
- ☐ Gynecological procedures
- ☐ Lung surgery
- ☐ Nasal or sinus surgery
- ☐ Orthopedic surgery
- ☐ Other head or neck surgery
- ☐ Removal of lymph node from neck
- ☐ Spine surgery
- ☐ Thyroid gland surgery
- ☐ Tonsillectomy/Adnoidectomy

Other ______________

SYSTEMS REVIEW PLEASE CHECK ALL THAT APPLY TO YOU:

Sleep: ☐ none ☐ loud snoring ☐ excessive daytime sleep ☐ trouble going to sleep ☐ trouble staying asleep

Constitutional: ☐ fever ☐ chills ☐ excessive weight loss or gain ☐ fatigue

Eyes: ☐ vision loss ☐ double vision ☐ tearing eyes ☐ worsening vision

Cardiovascular: ☐ palpitations ☐ racing heart ☐ chest pains ☐ cold/swollen extremities

Respiratory: ☐ wheezing ☐ dry cough ☐ productive cough ☐ night sweats ☐ shortness of breath

Gastrointestinal: ☐ increased/decreased appetite ☐ nausea vomiting ☐ abdominal pain diarrhea/constipation

Musculoskeletal: ☐ joint pain ☐ swelling ☐ stiffness ☐ muscle weakness

Integumentary: ☐ changes in skin lesion

Psychiatric: ☐ irritability ☐ depression ☐ anxiety insomnia ☐ drug or alcohol addiction (past or present)

Neurological: ☐ loss of smell or taste ☐ facial weakness or numbness ☐ memory problems ☐ headaches (how often) ______________ ☐ difficulty walking ☐ difficulty swallowing/speaking

Endocrine: ☐ increase in size of hands/feet ☐ heat/cold intolerance ☐ excessive thirst ☐ thyroid problem

Hematologic/Lymphatic: ☐ swollen nodes ☐ excessive bruising or bleeding

Allergic/immunologic: ☐ allergy to medicines ☐ seasonal allergies

Additional: ______________

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Financial Policy

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover, and Master Card.
2. To ensure correct billing, if you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a designated physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. All co-pays must be paid at the time of your service.
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits. Your insurance policy is a contract between you and your insurance company.
5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a Motor Vehicle Accident, payment in full is due at the time of the service.
6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.
7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full.
8. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office. In addition a $25 returned check fee will be added to your account.
9. If you have any questions, please call our billing office at 816-407-4200.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

______________________________	______________________________	__________
PATIENT/GUARDIAN'S SIGNATURE	PRINT PATIENT'S NAME & BIRTH DATE	DATE

Signature On File

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to The Ear, Nose & Throat Clinic. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for all charges whether or not covered by insurance.

______________________________	__________
SIGNATURE	DATE

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Permission to Disclose Information to Those Involved in My Care

I hereby allow The Ear, Nose & Throat Clinic to disclose the following information. (check all that apply)
This form does not authorize releasing copies of my medical records.

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information
- ☐ Other health information (describe)____

To the following people who are involved with my healthcare and/or payment information:
(check all that apply and list names and telephone numbers)

- ☐ Spouse_______________________________________ Phone:__________________
- ☐ Friend____ Phone:__________________
- ☐ Child(ren)_____________________________________ Phone:__________________
- ☐ Other____ Phone:__________________

Can confidential messages (i.e. appointment information, prescription information, test results)
be left on your answering machine or voicemail? (check all that apply how you wish to receive messages, and provide the phone number)

- ☐ No, DO NOT leave any messages
- ☐ Yes, at home, cell phone or work:

Home Phone:_________________Cell Phone:_________________Work Phone:________________

I understand that in certain situations The Ear, Nose & Throat Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permssion at any time.

Patient Name (please print):_____________________________________ Date of birth:______________

Patient/Guardian Signature:_______________________________________Date:___________________

If patient is a minor, please complete the following information:

Mother's name/contact number:____

Father's name/contact number:____

Patient Label

LIBERTY HOSPITAL
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

By signing this document, I acknowledge that I have received a copy of Liberty Hospital's Notice of Privacy Practices and Patient Rights.

Patient Signature: ___________________________________Date__________Time___

Patient Representative/Relationship Signature:

____Date__________Time___

Witness: ____ Date__________Time___

Liberty Hospital Use Only:

If the patient's signature was not obtained, please describe reason why below:

☐ Patient refused to sign Acknowledgement.

☐ Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

____
____
____

Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient's failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines

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Patient Name ________________________________ Date of Birth ____________________

Pediatrics

I ____________________________ parent/guardian of ____________________________
hereby give permission for the following individual(s) to pick up prescriptions for my child.
To ensure proper handling of all controlled substances, I understand they/I will be required to show proper photo identification each time.

1. ____
2. ____
3. ____

____

PHARMACY ALLOWED TO PICK UP SCRIPT

Adults

I hereby give permission for the following individual(s) to pick up my prescriptions in my absence.
To ensure proper handling of all controlled substances, I understand they/I will be required to show proper photo identification each time.

1. ____
2. ____
3. ____

____

PHARMACY ALLOWED TO PICK UP SCRIPT

☐ No one other than myself (patient) has permission to pick up my prescriptions.

____ ____________

SIGNATURE DATE