



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 _____

ILLCIT 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

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

Other _____

PAST SURGERIES OR TRAUMA HISTORY

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

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: _____



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

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 permission 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:_____



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

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



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

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