



Pradeep K. Sinha, MD, PhD, FACS  
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## PATIENT INFORMATION FORM

(Please Print)

LAST NAME				FIRST NAME			
ADDRESS						APT NUMBER	
CITY		STATE	ZIP CODE		E-MAIL ADDRESS		
SOCIAL SECURITY NUMBER			DATE OF BIRTH		MARITAL STATUS		SEX
WORK PHONE NUMBER		HOME PHONE NUMBER			MOBILE PHONE NUMBER		
INSURANCE COMPANY				PHONE NUMBER			
ADDRESS			CITY		STATE	ZIP CODE	
IDENTIFICATION NUMBER				GROUP NUMBER			
INSURANCE CARD HOLDER NAME					RELATIONSHIP TO PATIENT		
DATE OF BIRTH		SOCIAL SECURITY NUMBER		EMPLOYER		WORK NUMBER	
HOW DID YOU HEAR ABOUT OUR OFFICE?							
FAMILY PHYSICIAN				PHONE NUMBER			
PHYSICIAN'S ADDRESS, CITY, STATE, ZIP CODE							
EMERGENCY CONTACT NAME AND PHONE NUMBER							
NAME OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU AND PHONE NUMBER							
BRIEFLY DESCRIBE THE REASON FOR THE VISIT:							
I WILL BE PAYING TODAY BY: CASH / CHECK / CREDIT CARD							
<ul style="list-style-type: none"> <li>• I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and completed all the answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.</li> <li>• I hereby authorize payment of all medical benefits directly to Pradeep K. Sinha, MD, PC for medical services rendered.</li> <li>• I hereby authorize the release of any medical information necessary to process insurance claims.</li> </ul>							
Signature (Parent or Guardian if minor) _____						Date: _____	



# ATLANTA INSTITUTE FOR ENT & FACIAL AESTHETIC SURGERY

5445 MERIDIAN MARKS ROAD NE SUITE 370 • ATLANTA, GA 30342

404/257-1589 (VOICE) • 404/303-1950 (FAX)

Pradeep K. Sinha, MD  
Elizabeth A. Shaw, MD

## Past Medical History

**CHIEF COMPLAINT: (Please write in reason for this visit?) →**

Please include location, quality, severity, duration, timing, context, modifying factors and associated signs & symptoms

**REVIEW OF SYSTEMS: (Are you having any of the following?):**

GENERAL	Y	N
Fevers		
Night Sweats		
Weight Loss > 10 pounds (not intentional)		
Other (specify):		
<b>SKIN</b>		
Dryness		
Rash		
Other (specify):		
<b>HEAD AND NECK:</b>		
Headache		
Head Injury		
Eye Pain		
Visual Loss		
Deafness		
Decreased Hearing		
Ear Discharge		
Ear Infection		
Earache		
Tinnitus (ringing or noise in ear)		
Vertigo (dizziness)		
Epistaxis (nasal bleeding)		
Runny Nose (rhinitis)		
Sinus Pain		
Hoarseness		
Sore Throat		
Voice Changes		
Lymphadenopathy (swollen glands)		
Other (specify):		
<b>RESPIRATORY</b>		
Cough		
Hemoptysis (coughing blood)		
Sputum Production		
Wheezing		
Other (specify):		
<b>MUSCULOSKELETAL</b>		
Joint Pain		
Myalgia (muscle ache)		
Other(specify):		

CARDIOVASCULAR	Y	N
Chest Pain		
Hypertension (High Blood Pressure)		
Palpitations (heart skipping beats)		
Shortness of Breath		
Other (specify):		
<b>GASTROINTESTINAL</b>		
Dysphagia (difficulty swallowing)		
Nausea		
Vomiting		
Other (specify):		
<b>NEUROLOGIC</b>		
Headaches		
Paresthesias (tingling/numbness)		
Seizures		
Visual changes		
Weakness		
Other (specify):		
<b>PSYCHIATRIC</b>		
Anxiety		
Depression		
Hypersomnia (excessive sleeping)		
Inability to concentrate		
Insomnia (unable to sleep)		
Other (specify):		
<b>ENDOCRINE:</b>		
Cold Intolerance		
Hair Changes		
Heat Intolerance		
Other (specify):		
<b>HEMATOLOGY:</b>		
Easy bruising		
Enlarged lymph nodes		
Nose bleeds		
Prolonged bleeding		
Other (specify):		

**ALLERGIES (Please list medications, including over-the-counter, that you had had adverse reactions to):**  **NO ALLERGIES TO MEDICATIONS**

Medication allergy	Reaction type

Medication allergy	Reaction type

**IMMUNIZATIONS (UNDER 18 ONLY)** Please enter information about the following vaccine series:  **NO IMMUNIZATIONS RECEIVED**

Vaccine	✓ if series completed	If incomplete please indicate which shots have been received and date if possible:				
		1	2	3	4	5
Hepatitis B						
Diphtheria, Tetanus, Pertusis (DTP)						
Oral Polio Vaccine (OPV)						
Measles, Mumps, Rubella (MMR)						
Hemophilus Influenza Type B (HIB)						
Inactivated Polio Vaccine (EIPV)						

**OVER PLEASE →**

# Past Medical History

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## FAMILY HISTORY (Blood-related relatives with any of the following-please list relative):

Disease (list relative affected)	Y	N
<b>EAR, NOSE &amp; THROAT ( IN YOUR FAMILY MEMBERS)</b>		
Allergy Problems		
Hearing Loss		
Meniere's Disease		
Snoring/Sleep Apnea		
Other (specify):		
<b>CARDIOVASCULAR ( IN YOUR FAMILY MEMBERS)</b>		
Heart Attack		
Stroke		
Heart Disease		
High Blood Pressure		
Other (specify):		
<b>RESPIRATORY ( IN YOUR FAMILY MEMBERS)</b>		
Asthma		
Emphysema		
Pneumonia		
Other (specify):		
<b>ENDOCRINE (IN YOUR FAMILY MEMBERS)</b>		
Diabetes (if yes, requires insulin?)		
Thyroid Disease		
Parathyroid Disease		
Other (specify):		

Disease (list relative affected)	Y	N
<b>HEMATOLOGIC/ONCOLOGIC (IN YOUR FAMILY MEMBERS)</b>		
Thyroid Cancer		
Easy Bleeding or Bruising		
Frequent Infections		
Other (specify):		
<b>LIVER/GASTROINTESTINAL (IN YOUR FAMILY MEMBERS)</b>		
Liver Disease		
Hepatitis		
Other (specify):		
<b>NEUROLOGIC/PSYCHIATRIC (IN YOUR FAMILY MEMBERS)</b>		
Seizures		
Depression		
Weakness		
Schizophrenia		
Other (specify):		
<b>OTHER DISEASES IN YOUR FAMILY</b>		
Are there any other diseases that run in your family? →		
If yes, please specify in space below:		

## PAST MEDICAL HISTORY (Please list ALL YOUR ACTIVE OR PAST MEDICAL problems below): NO SIGNIFICANT PAST MEDICAL PROBLEMS

Condition	Year Diagnosed

Condition	Year Diagnosed

## PAST SURGICAL HISTORY (Please list all surgeries you have had-include surgeon's name is possible): NO PREVIOUS SURGERIES

Procedure / Surgeon	Date

Procedure / Surgeon	Date

## TRAVEL NO RECENT INTERNATIONAL / RURAL TRAVEL (If yes, Please list all recent travel) : →

## SOCIAL HISTORY: TOBACCO USE \_\_\_\_\_ ALCOHOL USE \_\_\_\_\_

## MEDICATIONS: (List below and may use back) NO CURRENT PRESCRIPTION, OVER-THE-COUNTER OR HERBAL MEDICATIONS TAKEN

Medication Name	Strength	Number	Route	Frequency	Reason
<i>Example: Tylenol</i>	<i>325 mg</i>	<i>2 capsules</i>	<i>By mouth</i>	<i>Every 6 hours</i>	<i>For pain</i>

## PREGNANCY/GYN HISTORY (FEMALES ONLY): Number of Pregnancies? \_\_\_\_\_ Deliveries? \_\_\_\_\_ Date of Last Menstrual Period? \_\_\_\_\_

## BIRTH HISTORY (under 18 only): Delivered at \_\_\_\_\_ weeks by vaginal / cesarean delivery which was spontaneous / induced / emergent. Details:

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

Signature (Guardian if patient is under 18 years of age) \_\_\_\_\_ Please Print Name \_\_\_\_\_ Relation to patient \_\_\_\_\_ Date \_\_\_\_\_



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## Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

The purpose of this policy is to let you know what is expected of you, in terms of payment for your treatment and the services provided by this office. We respectfully request that you read and sign this agreement prior to treatment at our facility.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN APPROVED BY OUR ACCOUNTS RECEIVABLE COORDINATOR. WE ACCEPT CASH, CHECKS, AND MOST CREDIT CARDS. WE ALSO OFFER FINANCING THROUGH AN OUTSIDER LENDER FOR COSMETIC PROCEDURES.**

We participate in a number of PPO and Group Benefit plans and if your insurance is one of those plans we do accept assignment. We cannot bill insurance companies for cosmetic surgical services. Any deductibles, co-insurances, or co-pays are due at the time of service. We need a copy of your insurance card prior to treatment so that insurance benefits can be verified. If we do not participate with your particular plan, we will be happy to bill your claim for you, but payment for services is due in full at the time of treatment. Your insurance company will in turn reimburse you directly.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, you will be billed for that balance. Any balances over 60 days old will be subject to an interest fee of 1 ½% of the balance due. You will be responsible for any charge denied by your insurance company deemed not medically necessary and/or not covered. Charges reduced by Usual and Customary Ratings, will be evaluated and possibly charged to you as well.

You will be responsible for any collection or attorney's fees should your account require collection efforts outside our office.

Any questions you have regarding this agreement should be directed to the Accounts Receivable Coordinator.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



# Use of Photographs for Medical Education, Science, or Research

## **Explanation**

This consent form authorizes this clinic and individual members of this clinic's staff to use these photographs for medical education, teaching, or research. Under so such circumstances will any publication or material bear your name. Your refusal to consent to the use of these photographs for medical education, teaching or research will in no way influence your treatment.

## **Consent**

In connection with the medical services that I am receiving from this clinic, the undersigned, consent to the taking of before, during and after treatment close-up photographs for the involved area(s) and the anatomical region surrounding the involved area(s).

I understand that the photographs shall be used for medical records and if, in the judgment of the physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other, in professional journals, or medical books, or used for any other purpose which the physician may deem proper in the interest of medical education, knowledge or research.

I authorize this clinic to admit to the operating room cameramen, photographers, technicians, and equipment designated for such purposes.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or publication of these photographs.

I release and hold harmless this clinic, staff, and consultants from any liability in connection with the use of such materials.

## **Limitations**

It is understood that the foregoing consent is subject to the following limitations:

Under no circumstances will any such publication, film photograph, videotape or material exhibited contain my name unless disclosed by me.

(Indicate any further limitation) \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Signature of Person Authorized to Consent for Patient**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Time**

\_\_\_\_\_  
**Witness**