Provider: _____________________________

Appointment Date: _____________________

Appointment Time: _____________________

Location: South Tampa Center for Advanced Healthcare (*see attached map)*

2 Tampa General Circle- 2nd Floor, Tampa Fl 33606

(813) 974-4683, option 1

To: All Patients

From: South Tampa Center for Advanced Healthcare

Re: Patient History Forms Attached

Thank you for choosing the South Tampa Center for Advanced Healthcare. For you convenience, we have enclosed a questionnaire and map to our facility; please bring it with you to your scheduled appointment.

It is recommended that you arrive 30 minutes prior to your appointment time. Patients who arrive 15 minutes after the scheduled time will be rescheduled. Patients who arrive at the wrong location will be rescheduled.

Please bring any medical records related to your care including hearing test, CD or films of X-rays, CT, MRI's.

If you require an interpreter, please bring an adult with you to provide translation between yourself, front desk staff, clinical staff and your physician.

Note If the appointment is for a minor, a parent or legal guardian MUST accompany the child and sign the consent to treat a minor in front of a witness at the time of the appointment. HOWEVER, if accompanied by anyone other than a parent, we will need either the court order stating that you have legal custody or a notarized letter from the parent stating that you are authorized to accompany the minor and consent to treat, or the minor will not be seen by the physician. You must bring this paperwork to every office visit and present at the time of check-in.

Parking: We are pleased to offer valet services in front of our building for a minimal charge.

By completing your new patient forms and bringing them with you, you will help avoid delays upon your arrival for your scheduled appointment. The temperature in the clinic becomes chilly at times, please bring a jacket to make yourself more comfortable. If you are a diabetic, please bring a snack in case you blood sugar runs low.

Thank you in advance for your cooperation.

Laura Pearce

Business Administrator, Department of Otolaryngology-Head and Neck Surgery

APPOINTMENT REMINDERS

As a service to our patients, we have implemented an appointment reminder system, House Calls, to provide you with a reminder of your next scheduled appointment. House Calls will either call, text, or email you two days prior to your next appointment to give you the date and time of your appointment. If you are unavailable when the call is made and have voicemail or an answering machine, the system will leave a brief message.

When you receive your appointment reminder phone call, it is very important to either confirm or cancel your appointment. Simply use your telephone keypad and press the following keys anytime during the message: Press the 1 Key to confirm your appointment

Press the 2 Key to replay the message

Press the 3 Key to cancel your appointment

CANCELLATIONS AND MISSED APPOINTMENTS

Within a 3 month period, two cancellations (cancel with less than 24 hours' notice) or missed appointments will result in warning letters. Third recurrence patient will receive a discharge letter which will restrict patient from scheduling future appointments with our department.

PLEASE READ

The faculty and staff of the USF Department of Otolaryngology – Head and Neck Surgery make the effort to make your experience with us as pleasant as possible. To that end, you can assist us by familiarizing yourself with the following:

You must have a valid insurance card and a picture ID with you at the time of service. Without these you will not be seen.

It is your responsibility to know your insurance benefits. It is not the responsibility of this office to verify medical eligibility.

It is your responsibility to be sure that the faculty of Otolaryngology are providers for your insurance company prior to making an appointment.

It is your responsibility to obtain a referral or authorization for the office visit and/or procedure. You must either verify that out office has received your referral/authorization or you must bring it with you to your scheduled appointment. If you do not have a referral or an authorization at the time of service, you will not be seen.

Co-payments, co-insurance, deductibles not met, and all past due balances will be collected prior to your visit. If you fail to pay in accordance with your insurance company's contract, you will not be seen.

If needed, it is your responsibility to bring a translator with you to all appointments. A minor child is not acceptable; you must bring an adult family member or friend.

ATTENTION FOSTER PARENTS OR LEGAL GUARDIANS

Foster Parents – you must bring a copy of the court order stating that you have legal custody or the minor will not be seen. You must bring this to every office visit and present at the time of check-in.

Legal Guardians – you must bring a NOTARIZED note from the parent stating that you are authorized to accompany the minor and consent to treatment. Unless otherwise stated in the note, a new note will be required for every visit, or the minor will not be seen.

PATIENT HEALTH QUESTIONNAIRE: Otolaryngology - Head and Neck Surgery

Patient Name:____ Medical Record #: ____________________

Last First MI

Email address: ____ Phone #: ____________________________

Age:__________ **Sex:** ☐ Male ☐ Female Date of Birth: _________________________

Type of visit: ☐ Consultation requested by another Physician ☐ Self-referred ☐ Second Opinion

PHYSICIAN INFORMATION

Primary Care MD:______________________________ Specialty: ________________________________

Address:____

Phone:______________________________________ Fax:______________________________________

Referring Physician:______________________________ Specialty:_______________________________

Address:____

Phone:______________________________________ Fax:______________________________________

Would you like your records to go to any other physician? ☐ Yes ☐ No

Other Physician:______________________________ Specialty:_______________________________

Address:____

Phone:______________________________________ Fax:______________________________________

PERSONAL HISTORY

☐ Married ☐ Widowed ☐ Divorced ☐ Single

Occupation:____How long?___________________________

Currently Employed? ☐ Yes ☐ No

Do you live? ☐With spouse/family ☐Alone With others ☐ Do you have a living will or advance directive? Yes No ☐ ☐

PLEASE NOTE THE REASON FOR YOUR VISIT TODAY:

____

____

____

C. **ALLERGIES** *(Specify drug and reaction)*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

D. **MEDICATIONS/ DOSE/ FREQUENCY** *(Include over the counter medications, herbal products, supplements and vitamins)*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Department of Otolaryngology University of South Florida
College of Medicine– Head and Neck Surgery

Mailing: 12901 Bruce B. Downs Blvd. MDC Box 73
Tampa, FL 33612

E. **PAST MEDICAL HISTORY:** *(Include all hospitalizations, chronic health problems, major illnesses)*

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

F. **PAST SURGICAL HISTORY:** *(List all past surgeries)*

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

G. **SOCIAL HISTORY:** *(Tobacco, caffeine, alcohol, drug use)*

Do you currently smoke cigarettes? ☐ Yes ☐No How many years?____________________
# of packs per day____________________

Have you used tobacco products like cigars, pipes, or smokeless tobacco? ☐Yes No How many years?____________________ # per day____________________________

Do you currently consume alcohol? ☐ Yes ☐ No How many years?____________________
What type?______________________________ Amount per day:____________________________________

Have you used illegal drugs *(marijuana, cocaine)*? ☐ Yes ☐ No How many years?_____________
What kind?______________________________ Amount per day:____________________________________

Have you received treatment for substance abuse? ☐ Yes ☐No

How many cups of coffee/caffeine drinks do you drink daily?_______________

H. **FAMILY HISTORY**

Family Member	Age	Living	Deceased	Illnesses*	Cause of Death	General Health
Father						
Mother						
Brothers						
Sisters						
Children *(indicate sex)*						

***Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.**

I. REVIEW OF SYSTEMS: *Check all responses that apply.*

General	**Yes**	**No**
Weight gain/loss	☐	☐
Difficulty falling asleep	☐	☐
Need to cut down alcohol consumption	☐	☐
Fever	☐	☐
Change in appetite	☐	☐

Skin	**Yes**	**No**
Rash, sore,or excessive bruising	☐	☐
Lump or growth on skin	☐	☐

Eyes	**Yes**	**No**
Wear glasses	☐	☐
Decreased vision	☐	☐
Pain in eyes	☐	☐

Ears, Nose, Throat, Mouth

Yes **No**	☐	☐
Difficulty or changes in hearing	☐	☐
Earaches	☐	☐
Discharge from ears	☐	☐
Buzzing or ringing in ears	☐	☐
Frequent sneezing	☐	☐
Nose stuffiness or running	☐	☐
Recurrent sore throat	☐	☐
Persistent hoarseness	☐	☐
Dental problems	☐	☐
Sinus problems	☐	☐
Lymph glands or nodes frequent nose bleeds	☐	☐

Genitourinary	**Yes**	**No**
Painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Difficulty emptying bladder	☐	☐

Musculoskeletal	**Yes**	**No**
Painful joints	☐	☐
Sore muscles	☐	☐
Back pain	☐	☐
Pain in calves of legs	☐	☐
Weakness in extremities	☐	☐
Numbness in extremities	☐	☐

Neuropsychiatric	**Yes**	**No**
Anxiety	☐	☐
Depression	☐	☐
Frequent or severe headaches	☐	☐
Dizziness or faintness	☐	☐
More nervous than average person	☐	☐

Cardiovascular	**Yes**	
No Chest pain	☐	☐
Shortness of breath	☐	☐
Abnormal swelling in legs/feet	☐	☐
Fatigue or tire easily	☐	☐

Respiratory

Yes **No**

Cough	☐	☐
Blood in sputum	☐	☐
Wheezing	☐	☐

Endocrine	**Yes**	**No**
Excessive thirst or urination	☐	☐
Change in sexual drive/performance	☐	☐
Change in heat or cold tolerance	☐	☐

Gastrointestinal	**Yes**	**No**
Frequent heartburn/indigestion	☐	☐
Nausea or vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Ulcers	☐	☐

For Women only	**Yes**	**No**
Irregular periods	☐	☐
Bleeding between periods	☐	☐
Are you pregnant	☐	☐
Date of last menstrual period	__/__/__	
Ever have an abnormal Pap smear Lump	☐	☐
or growth on breast	☐	☐

Allergic/Immunologic		
Hayfever	☐	☐
Hives	☐	☐
Immunodeficiency	☐	☐

Hematologic/Lymphatic Anemia	☐	☐
Excessive Bleeding or Bruising	☐	☐
Blood Transfusion	☐	☐

Reviewed by:

_________________________________MD___________Date

___________________________ LPN/MA/RN ____________Date

Department of Otolaryngology – Head & Neck Surgery
Tampa, Florida

USF HEALTH

ATTENTION ENT PATIENTS

IT IS OFTEN NECESSARY FOR A SCOPING PROCEDURE TO BE PERFORMED DURING YOUR OFFICE VISIT SO THAT AN ACCURATE DIAGNOSIS CAN BE MADE BY YOUR PROVIDER. A SCOPING PROCEDURE MAY ALSO BE NECESSARY TO MONITOR YOUR PROGRESS FOLLOWING SURGERY OR OTHER TREATMENT PLAN PROGRESS.

MANY INSURANCE COMPANIES NOW CONSIDER THIS PROCEDURE TO BE SEPARATE FROM YOUR
OFFICE VISIT AND HAVE IMPLEMENTED A CO-PAY OR DEDUCTIBLE REQUIREMENT THAT IS IN ADDITION TO THE CO-PAY OR DEDUCTIBLE REQUIRED FOR YOUR OFFICE VISIT. PLEASE NOTE THAT THIS IS A CHANGE MADE BY YOUR INSURANCE COMPANY TO YOUR BENEFIT PLAN NOT A CHANGE MADE BY YOUR PROVIDER OR THE USFPG. IF YOU SHOULD CHOOSE NOT TO BE SCOPED PLEASE UNDERSTAND WE MAY NOT BE ABLE TO PROVIDE YOU WITH CONTINUED CARE.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE COVERAGE AND LIMITS OF YOUR BENEFIT PLAN HOWEVER, WE WILL ASSIST YOU IN ANY WAY POSSIBLE.

Thank you for your attention to this matter.

Laura Pearce
Business Administrator
Department of Otolaryngology - Head & Neck Surgery

____
Print Patient Name

____ ______________________________
Patient Signature Date

Procedure codes (*if applicable*):
31231 – nasal scopes
31575 – laryngeoscope
31576 – flex with bx laryngeoscope
31237 – nasal scope with sinus debridement

Affix Label Here

Mailing Address (all locations): 12901 Bruce B. Downs Blvd. MDC 73 Tampa, Fl 33612
http://health.usf.edu/medicine/ent

Department of Otolaryngology – Head & Neck Surgery
Tampa, Florida

USFPG

Consent for E-Mail Communication

USFPG offers patients the ability to communicate with providers via electronic mail (e-mail) for non-urgent matters if, the arrangement is agreed to by both parties.

Privacy and Security of the E-Mail:

Do not use e-mail to send or request very sensitive information. USFPG cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is potential that e-mail sent over the Internet can be intercepted, and read by others. If this is of concern to you, you should not communicate with your provider through e-mail.

I have been informed of and understand the risks and procedures involved with suing e-mail. I agree to the terms listed above and I hereby voluntarily request the use of e-mail as one form of communication with my physician or other health care provider.

Email address: ____

____
Print Patient Name

______________________________ ______________________________
Patient Signature Date

Affix Label Here

Mailing Address (all locations): 12901 Bruce B. Downs Blvd. MDC 73 Tampa, Fl 33612 http://health.usf.edu