PATIENT INFORMATION RECORD

Referring Doctor	Date

Patient's Name	Marital Status	Date of Birth	Age	Sex
Street Address	Home Phone	Cell Phone	Social Security No.	
City, State, Zip Code	Spouse's Name		Date of Birth	

Patient's Employer	Business Phone	Spouse's Employer
Employer's Address		Spouse's Employer Address
Patient's Occupation		Spouse's Business Phone
Insurance # 1		Name of Insured /Date of Birth:
Insurance #2		Name of Insured /Date of Birth:

Relative or Friend (Not Living With You)	Address	Phone No.

Are you HIV Positive?	Do You Have any drug allergies?	Do You Have Any Serious Medical Problems?
❑ No ❑ Yes	❑ No ❑ Yes If yes Explain ________	❑ No ❑ Yes If yes Explain ________

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER AND PAYMENT DIRECTLY TO MY PHYSICIAN FOR ALL SERVICES LISTED ON THE ATTACHED HEALTH INSURANCE CLAIM FORM. I UNDERSTAND THAT SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY.

Email Address: ____________________

____
Patient or Parent's Signature

IF PATIENT IS A MINOR OR STUDENT

Person Responsible for Payment		Relationship	Phone
Mother	Date of Birth	Father	Date of Birth
Social Security No.		Social Security No.	
Address		Address	
City, State, Zip Code		City, State, Zip Code	
Home Phone	Work Phone	Home Phone	Work Phone
Employer		Employer	
Employer Address		Employer Address	

REFERRAL SOURCE:

❑ locateadoc.com ❑ Internal ❑ Friends ❑ Yellow Pages ❑ PippinMD.com ❑ Physician________

❑ ENTNewOrleans.com ❑ Other________________

THOMAS M. IRWIN, JR., M.D.
JOHN G. KIMBLE, M.D.
ANNE E. B. LONG, M.D.
GREGORY W. PIPPIN, M.D.
ADIL FATAKIA, M.D., M.B.A.
A Professional Medical Corporation

Otolaryngology / Head and Neck Surgery
Facial Plastic & Reconstructive Surgery
Cosmetic Surgery
PippinMD.com

West Jefferson Physicians Center
1111 Medical Center Blvd., Suite N406
Marrero, Louisiana 70072
Phone: (504) 349-6400
Fax: (504) 349-6407
ENTNewOrleans.com

PLEASE PRINT

Patient ______________________ Phone ______________ Date ______________

Address ____

City ______________________ State ______________ Zip Code # ______________

Age ______ Sex ______ Birth Date __________ Marital Status ________ Spouse __________

Occupation ____

Employer ________________ Address ________________ Phone ______________

Referred By ____

Family Doctor ____

PLEASE DO NOT WRITE BELOW THIS LINE

Known Drug Allergies:

Chief Complaints:

History:
Previous Serious Illnesses:
Previous Surgery:
Bleeding:
Allergies:
Smoke:
Family History:
Drugs:

Findings:
L. Ear:
R. Ear:
Nose:
Nasopharynx:
Oropharynx:
Hypopharynx-Larynx:
Neck:

Impressions:
Diagnosis:
Recommendations:

PATIENT NAME: ______________________ DATE: ______________

HEIGHT :__________________ WEIGHT :____________________

PLEASE LIST ANY MEDICATIONS YOU TAKE REGULARLY:

____

____

____

LIST ANY MEDICAL CONDITIONS:

____

____

____

LIST ANY PREVIOUS SURGERIES:

____

____

PLEASE LIST ANY DRUG ALLERGIES YOU MAY HAVE:

____

____

PLEASE LIST ANY DOCTORS WHO PARTICIPATE IN YOUR CARE:

____

____

DO YOU SMOKE? __________________ HOW MUCH? ______________

DO YOU DRINK ALCOHOL? ____________HOW MUCH? ______________

ARE THERE ANY DISEASES THAT RUN IN YOUR FAMILY? ________________

ENT OF NEW ORLEANS

Drs. Irwin, Kimble, Long, Pippin and Fatakia

ACKNOWLEDGEMENT / REVIEW OF: NOTICE OF PRIVACY PRACTICES

x_______ I have been provided with this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ ______________________

Signature of Patient/Parent Date

x_________The following family members are allowed at anytime to get a copy of my medical records or receive information concerning my medical care.

Name:_______________________________________Relationship: _______________________

NO SHOW POLICY

x_______ We understand that circumstances arise that may cause you to miss your appointment, but please remember to be courteous to us and our other patients by calling 24 hours prior to your appointment to cancel if you cannot make it. When a scheduled appointment is missed then valuable physician time is wasted. If you miss an appointment and have failed to give us 24 hour notice, then there will be a $25 no-show fee applied to your account. Also, please note that if you are more than 15 minutes late for your appointment, it will be considered a no-show. While this may seem extreme to some, please realize that this help keep missed appointments to a minimum and ensure that other patients can be seen when needed. If you have any questions, please feel free to ask our staff, including the doctor.

Parent/Patient Signature: _______________________________ Date: ______________________

MEDICAID SECONDARY POLICY

I, _________________________________ understand that I have been advised that effective October 1, 2013, Drs. Irwin, Kimble, Long, Pippin and Fatakia's group no longer accepts secondary coverage through Medicaid. I also understand that I am responsible for any co-payments or co-insurance that my primary insurance leaves as a balance due to this policy.

Parent/Patient Signature: _______________________________ Date: ______________________

Witness: ____ Date: ______________________