EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

James R. Gaul, M.D.
Michael J. Kelleher, M.D.
Daniel J. Kelley, M.D.
Laura M. King, PA-C

Otolaryngology

Head and Neck Cancer

Pediatric Otolaryngology

Facial Plastic Surgery

Allergy Management

Balance Disorders

Audiology

Thyroid/Parathyroid Surgery

Thank you for choosing Drs. Gaul, Kelleher and Kelley for your medical care. The Physicians and Staff at Eastern Shore ENT & Allergy look forward to providing you with the highest quality care. To help expedite the check in process, we ask that you complete the enclosed forms. Please be certain to answer all questions, including the yes or no questions on the medical history, and sign both forms. You will need to bring the completed forms, a list of your current medications with the dosage, and your current insurance cards with you at the time of your appointment.

If your health insurance company requires a referral you must contact your Primary Care Physician to obtain the referral prior to arriving for your appointment. Health insurance companies requiring a referral will not authorize us to see you without this written referral.

For first time patients under the age of 18 a parent or legal guardian must accompany the patient to the first office visit.
For follow up appointments after the first visit you may send written consent for someone other than parent or legal guardian to bring the patient to their appointments. Keep in mind we will be unable to see the patient without this information. We must have this on file for future visits.

We will make every effort to see our patients as close to their appointment time as possible. However, we are a surgical practice and are subject to emergency circumstances that are beyond our control. We ask you for your patience should any delays occur. Any missed appointments will be charged a $40.00 fee, please notify us within 24 hours of cancelling.

The Physicians and Staff here at Eastern Shore ENT & Allergy look forward to providing you with the highest quality medical care.

Drs Gaul, Kelleher, Kelley and Staff

106 Milford Street
Suite 101
Salisbury, MD 21804
410.742.1567
Fax: 410.742.1906

124 N Main Street
Berlin, MD 21811
410.641.4582

TTY USERS CALL MARYLAND RELAY #711

PATIENT REGISTRATION

Date: ____________________

Patient Name: ____
Last First MI

Home Address: ____

Mailing Address: ____
(if different from above)

Preferred phone: ________________________ **Alternative Phone:** ________________________ **Race:** ______________

Email Address: ____

Date of Birth: ________ **Sex:** (M/F) ___ **Soc. Sec.** # ____________________ **Marital status:** S___ M___ D___ W____

Patient's Employer: ______________________________ **Work Phone:** ______________________________

Primary Physician: ______________________________ **Referring Physician:** ______________________________

Address: ______________________________ **Address:** ______________________________

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Insured or Parent/Guardian information (this MUST be completed if patient is under the age of 18 or is not the insured)

Insured or Parent/ Guardian Name: ______________________________________ **Date of Birth:** ________________

Relationship to patient: ______________________________ **Soc. Sec. #** ______________________________

Address: ____

Employer: ______________________________ **Work Phone#** ______________________________

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Emergency Contact:

Name: ________________________ **Phone#:** ________________________ **Relationship:** ________________

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Pharmacy Name: ______________________________ **Phone: #** ______________________________

Address: ____

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In the future, how would you prefer to receive reminders such as appointments, Rx, labs, billing, etc? (Choose all that apply) Email_________ Phone_________ Text Messages_________

Do you have internet access on a regular basis? YES or NO

In the future, would you be interested in being Web Enabled? This will allow you to complete forms and look at available schedule slots (among other things) on the web for our practice? YES or NO

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Patient Authorization

I authorize Eastern Shore ENT & Allergy, P.A. (ESENTA) to provide medical care and treatment to myself or patient named above if under the age of 18. I authorized ESENTA to apply for benefits on the patient's behalf of services rendered. I request the insurance make payment directly to ESENTA. I certify that the insurance coverage is correct. I further authorized the release of information, including medical information of any care or treatment for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing prior to future treatment. My signature below indicates I have read and understand this authorization. I understand and agree to be fully responsible for payment of any service provided, including deductibles, copayments and non-covered services at the time of service, unless other arrangements have been made.

____

Patient Signature (Guardian Signature if patient is under the age of 18)

Name:______________________________DOB:______________________Date:____________

Are you having any of the following symptoms ***TODAY***? Please check "YES" or "NO" only.

GENERAL/CONSTITUTIONAL

Symptom		
Change in appetite	Yes	No
Chills	Yes	No
Fever	Yes	No

ALLERGY/IMMUNOLOGY

Symptom		
Hives	Yes	No
Itching	Yes	No
Rash	Yes	No
Wheezing	Yes	No
History of Immune deficiency	Yes	No

OPTHALMOLOGIC

Symptom		
Blurred vision	Yes	No
Dry Eye	Yes	No
Pain	Yes	No

ENDOCRINE

Symptom		
Cold intolerance	Yes	No
Excessive thirst	Yes	No
Frequent urination	Yes	No
Heat intolerance	Yes	No
Weight loss	Yes	No

RESPIRATORY

Symptom		
Coughing up blood	Yes	No
Pain with inspiration	Yes	No
Sputum production	Yes	No
Wheezing	Yes	No

CARDIOVASCULAR

Symptom		
Chest pain at rest	Yes	No
Difficulty laying flat	Yes	No
Irregular heartbeat	Yes	No

GASTROINTESTINAL

Symptom		
Abdominal pain	Yes	No
Blood in stool	Yes	No
Change in bowel habits	Yes	No
Constipation	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

MUSCULOSKELETAL

Symptom		
Carpel Tunnel	Yes	No
Muscle Aches	Yes	No

PERIPHERAL VASCULAR

Symptom		
Ulceration of feet	Yes	No

SKIN

Symptom		
Hives	Yes	No
Itching	Yes	No
Rash	Yes	No

NEUROLOGIC

Symptom		
Tics	Yes	No
Loss of use of extremity	Yes	No
Tremor	Yes	No

PSYCHIATRIC

Symptom		
Mental or Physical abuse	Yes	No
Delusions	Yes	No

NAME________________________ DOB:______________ SS# ______________

PAST MEDICAL HISTORY

Acid reflux	yes	no	Hyperthyroidism	yes	no	Heart disease	yes	no
Heart attack	yes	no	Hypothyroidism	yes	no	Depression	yes	no
Sleep apnea	yes	no	Kidney disease	yes	no	Asthma	yes	no
Atrial fibrillation	yes	no	Lyme disease	yes	no	Lupus	yes	no
Carotid stenosis	yes	no	Malig. hyperthermia	yes	no	Epilepsy	yes	no
Cataracts	yes	no	Melanoma	yes	no	Thyroid Nodule	yes	no
Congestive heart failure	yes	no	Mitral valve prolapse	yes	no	High cholesterol	yes	no
COPD	yes	no	Multinodular goiter	yes	no	Hepatitis	yes	no
Deep vein thrombosis	yes	no	Organ Transplant	yes	no	High Blood pressure	yes	no
Diabetes	yes	no	Pulmonary embolism	yes	no	Cancer	yes	no
Emphysema	yes	no	Sarcoidosis	yes	no	Type of Cancer: ____________		
End stage renal disease	yes	no	Stroke	yes	no	______________________		
Grave's disease	yes	no	Bleeding disorder	yes	no	Other: ________________		

Do you have a pacemaker? Yes or no
Do you have a defibrillator? Yes or no
Do you use CPAP or BiPAP machine? Yes or no

Drug Allergies, including contrast dye: (if yes, list specific reaction)

____
____

Past Surgeries or Hospitalizations:

____
____

Past Family History: (if yes, specify relationship):

Allergies:______________	Hearing loss______________	Malignant Hyperthermia__________
Cancer______________	Heart disease______________	Stroke______________
Diabetes______________	Hypertension______________	Other______________

Social History: (please circle)

Are you a: current smoker former smoker non-smoker
How often do you smoke? : every day some days
How many cigarettes do you smoke a day? : 5 or less 6-10 11-20 21-30 31 or more
How soon after you wake up do you smoke? 5 min. 6-30 min. 31-60 min. after 60 min.
Are you interested in quitting? Yes or No

Did you drink alcohol in the past year? Yes or No
How often do you have alcohol? Never Monthly 2-4 times a month 2-3 times a week 4 or more times a week
How much alcohol do you drink in a typical day? 1-2 3-4 5-6 7-9 more than 10 a day
How often do you have more than 6 drinks on one occasion? Never Less than Monthly Monthly Weekly Daily

Do you have any religious beliefs which prohibit Medical Treatment? Yes or No
If yes, please explain:____

EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

JAMES R. GAUL · MICHAEL J. KELLEHER · DANIEL J. KELLEY M.D., F.A.C.S.
Offices located in Salisbury & Berlin
phone: +1 (410) 742-1567 fax: +1 (410) 742-1906

Medication List as of _____/_____/_____

Patient Name ______________________________ Date Of Birth:_____/_____/_____

Medication Name	Dosage Amount	Frequency

EASTERN SHORE ENT & ALLERGY ASSOCIATES PA

COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS & AGREEMENTS

ASSIGNMENT OF BENEFITS - I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any service furnished and that as such payment(s) be paid directly to the provider of service. I also understand that I am financially responsible for all services provided and agree to pay upon demand or as agreed for the related charges or remaining charges following my insurance payment(s).

CO-PAYS - I understand all co-pays will be collected at the time of service.

PRIOR BALANCES - All prior balances must be reconciled either by mail prior to, or at my next visit, whichever is sooner. The office accepts cash, check, money order, VISA, MASTERCARD and DISCOVER.

RETURNED CHECKS FEE - A $25.00 returned check fee will be applied to my account for all returned checks and we will NOT redeposit the check a second time. I will be required to pay the amount due by cash or money order.

MISSED APPOINTMENT FEE - I understand I may be charged a fee if I miss my appointment or do not cancel at least 24 hours prior to my appointment. This fee is not covered by my insurance carrier and must be paid prior to my next appointment.

COLLECTION FEES - I understand and acknowledge that if the patients account becomes delinquent (over 60 days), account balances (inclusive of all charges and reasonable collection costs including but not limited to reasonable collection agency/attorneys fees) may be sent to our collection agency/lawyer for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees and court costs. In consideration of the acceptance of the patient named on this form by Eastern Shore ENT & Allergy Associates, PA and for services rendered or to be rendered to the patient, the undersigned promises to pay for and guarantees payment for all amounts due and any and all charges including collection costs described. If payments due are not made as agreed, Eastern Shore ENT & Allergy Associates, PA may, without notice or demand, declare the entire unpaid balance of the account including collection costs agreed to as described to be immediately due and payable. If court action is necessary to enforce payment, the venue for any such court action shall be Wicomico County, Maryland unless Provider elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be made as valid as the original.

I HAVE READ, ACKNOWLEDGE AND AGREE TO ALL OF THE ABOVE COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS AND AGREEMENTS.

Patient Name:______________________________________**Date of Birth:**________________

Print & Signature

Guarantor
Name:____**Relationship:**________________

Print & Signature

Date:_______/_______/_______

PATIENT ACKNOWLEDGMENT FORM

Use & Disclosure of
Protected Health Information

Eastern Shore ENT & Allergy Associates, P.A.'s "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge review and receipt, if requested, of this office's **Notice of Privacy Practices** by initialing below:

____
Patient/Legal guardian

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy, if requested, either by mail or at your next appointment.

____
Patient/Legal guardian

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

____
Patient/Legal guardian

By signing this form, you consent to our use, disclosure and receipt of protected health information about you for treatment, payment, and health care operations. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

Eastern Shore ENT & Allergy Associates, P.A. is authorized to discuss my medical health and treatment with:

____
Name and Relationship of Individual (s) (if no one state "no one")

____
Name and Relationship of Individual

____
Name and Relationship of Individual

____
Name and Relationship of Individual

____
Signature Patient/Legal guardian ***Date***