

ONLINE FORM SUBMISSION INSTRUCTIONS

Please read carefully

1. Please fill out form.
2. When form is complete, please press "submit form."
3. Follow Adobe submission instructions:
 - a. Choose email method. (*Direct submission or as an attachment*).
 - b. If choosing to send forms as an attachment, please save completed form and send to: DoNotReply@flotogroup.com
 - c. **Please note, we cannot respond to email send to this address. If you have a question, please contact our office directly. If you have an emergency, please dial 911.**
4. Await confirmation email. (*If you do not receive a confirmation email, our office did not receive your form. Please print and bring form to appointment*).
5. Please select your appointment time and location below. (If you do not know, please leave blank).

Appointment Location:

Appointment Date:

Thank you for choosing Florida Otolaryngology Group, P.A.

Your Family's Ear, Nose and Throat Physicians

Clifford B. Dubbin, M.D., F.A.C.S.
Michael S. Mokris, M.D., F.A.C.S.
Bradley R. Reese, M.D., F.A.C.S.
Alan J. Saffran, M.D., F.A.C.S.

**FLORIDA
OTOLARYNGOLOGY
GROUP, P.A.**

John F. Huhn, M.D., F.A.C.S.
Gregory N. Boger, M.D.
Richard F. Clark, P.A. - C.

PATIENT INFORMATION

Please Print

Today's Date: _____ Patient Chart#: _____

Patient Name: _____ Age: _____ Sex: _____

Address: _____ Date of Birth _____

City _____ State _____ Zip: _____ Marital Status: "aaaaaaaaaaaaaaaaaaaaaaaaaaaa"

Telephone: Home#: _____ Cell#: _____ Patient's S.S.#: _____

Do you have an alternate address: Yes ___ No ___ If yes, please print here _____

Employer: _____ Work Phone #: _____

Husband (or Father, if a minor): _____

Name S.S. # Birth Date

Address Home Phone Alternate Phone

Wife (or Mother, if a minor): _____

Name S.S. # Birth Date

Address Home Phone Alternate Phone

Name of closest relative not living with you: _____

Relationship Telephone #

HEALTH INFORMATION

Referring Physician: _____

Address: _____ Zip: _____ Telephone: _____

Primary Care Physician: _____

Reason for seeing Doctor today: _____

INSURANCE INFORMATION

1st Insurance Co.: _____ 2nd Insurance Co.: _____

Policy Holder: _____ Date of Birth _____ Policy Holder: _____ Date of Birth _____

Patient Relationship to the Policy Holder: _____ Patient Relationship to the Policy Holder: _____

Insurance Telephone: _____ Insurance Telephone: _____

I.D. # _____ Group # _____ I.D. # _____ Group # _____

Effective Date: _____ Effective Date: _____

As a courtesy, our practice will file your insurance claims. However, it is your responsibility to supply us with current and correct information and to know your policy requirements and limitations.

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Otolaryngology Group, P.A. or any of the physicians within the group. I realize I am responsible for paying any applicable co-pay, coinsurance, deductible or non-covered services.

Patient Signature: _____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance carriers or for continuing patient care.

Any of the classifications above may be crossed off if that information is not to be released.

Patient Signature: _____

FOR MEDICARE PATIENTS ONLY

MEDIGAP STATEMENT

Health Insurance Claim Number: _____

Medigap Policy Number: _____

I request that payment of authorized Medigap benefits be made on my behalf to FLORIDA OTOLARYNGOLOGY GROUP, P.A. for any services furnished me by FLORIDA OTOLARYNGOLOGY GROUP, P.A.

I authorize any holder of medical information about me to release to (name of Medigap insurer) _____ any information needed to determine these benefits on the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Signature of Beneficiary: _____ Today's Date _____

MEDICARE PART B SIGNATURE AUTHORIZATION LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Name: _____ Patient Signature: _____

Medicare B # _____ Date: _____

PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED

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MEDICAL HISTORY

Please Print

Today's Date: _____

BP: _____ Ht.: _____ Wt.: _____

Patient Name: _____ D.O.B. _____ Sex: _____

HEALTH HISTORY OF THE PATIENT

	Yes	No
Anesthesia Problems		
Asthma		
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Acid Reflux		
Nasal Allergies		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
HIV/AIDS		
Liver Trouble		
Thyroid Trouble		
Stomach Ulcer		
Sleep Apnea		
Other Illnesses		
Explain all Yes answers		

FAMILY HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Anesthesia Problems		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		
Explain all Yes answers		

Cause of death of parents, or brothers or sisters

REVIEW OF SYMPTOMS CONTINUED

Have you recently had or do you now have:

	Yes	No
Persistent Snoring		
Hoarseness		
Difficulty Swallowing		
Chest Pain/Discomfort		
Abnormal Heartbeat		
Shortness of Breath		
Calf Cramps While Walking		
Ankle Swelling		
Cough		
Wheezing		
Pain on Breathing		
Coughing Blood		
Heartburn		
Nausea/Vomiting		
Stomach Pain		
Frequent Belching		
Frequent Loose Bowel Movement		
Frequent Constipation		
Blood in Bowel Movements		
Hemorrhoids		
Frequent Urination		
Burning on Urination		
Blood in Urine		
Difficulty Starting Urination		
Getting up Every Night to Urinate		
Flank Pain		
Joint Aches		
Muscle Aches		
Swollen Glands		
Bleeding Problems		
Easy Bruisability		
Hair Loss		
Constantly Thirsty		
Constantly Hungry		
Hot or Cold Spells		
Rashes		
Hives		
Hair Changes		
Frequent Headaches		
Seizures		
Blackouts		
Tremors		
Numbness		
Tingling		
Insomnia		
Anxiety/Panic		
Depression		
Women Only		
Are you Pregnant?		
Are You Nursing?		

REVIEW OF SYMPTOMS

Have you recently had or do you now have:

	Yes	No
Chills or Fever		
Night Sweats		
Recent Weight Change		
Poor Appetite		
Fatigue		
Reading Glasses		
Changes in Vision		
Eyes Sensitive to Light		
Watery/Itchy Eyes		
Hearing Loss		
Ringin/Buzzing in Ears		
Ear Pain		
Nasal Congestion		
Nosebleeds		
Sinus Pressure		
Dry Mouth		
Gum Trouble		
Toothache		

SOCIAL HISTORY

Smoke _____ packs/day for _____ years
 Alcohol: Never Occasional
 Moderate to Heavy
 Drug Overuse: None
 Presently Past Problem
 Most Recent Occupation: _____
 Married Single Divorced
 Number of Children Living
 Number of Pregnancies
 Presently Living Alone? Yes No

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

- _____ (Initials) Our doctors may require tests and diagnostic or surgical office procedures in order to provide quality medical care. **Depending on your insurance coverage, these may require an additional co-pay or surgical deductible.**
- Please be sure that we are providers for your insurance plan. Our staff will do its best to inform you if our doctors are out-of-network; however, it is your responsibility to know your insurance plan.
- Some insurance benefits may not cover all services provided by a doctor. Your benefits are based on a contract between you (or your employer) and the insurance company. It is essential that you understand your health benefits and plan requirements.
- Our office needs your complete insurance information to file your charges. If we do not have this information at the time of the appointment, you may be rescheduled, or our office may require payment in full at the time of service.
- If your health insurance plan requires a referral from a primary care physician, your appointment will be rescheduled if we have not received authorization from your doctor. Although our staff will try to assist in confirming that a referral has been issued, it is the patient's responsibility to obtain authorization from their PCP.
- Any outstanding patient balance will be considered past due 30 days after the first bill is mailed. After 60 days the balance may be forwarded to an outside collections agency. Our office will try to assist in any insurance issues that may arise; however, patients (or their guardians), not the insurance company, are ultimately responsible for paying their medical bills. We are not party to any dispute between the insurance company and the insurance subscriber. Prompt payment is expected when a bill has been mailed.



- Our office will charge \$15 for returned checks.
- If you are unable to keep your appointment, please notify our office at least 24 hours prior to the scheduled time. This will allow us to offer this time to other patients in need. You may be charged a \$25 No-Show Fee if our office is not notified within 24 hours of your appointment time. This fee is not covered by insurance and will be your responsibility.
- There is a \$25 charge for completing disability, FMLA and other insurance forms. It is the responsibility of the patient to pay this fee prior to completion of the form. Our policy is to allow 7-14 days for processing of the form. We require that the patient information, employer information and other personal sections be completed before accepting the form. *Please leave all sections to be completed by the physician blank.*

I have reviewed and understand the above policies.

Patient (Guardian) Signature

Date

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HIPAA Consent

I hereby acknowledge that I have been informed of Florida Otolaryngology Group, P.A.'s. Notice of Privacy Practices posted in the office lobby and have the right to a copy of this document upon request.

Florida Otolaryngology Group, P.A. may discuss information regarding my treatment and care with the following individuals. This could be in person, by telephone, fax, or by mail and includes the following information. If no one, indicate "no one."

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Please initial each of the following you are authorizing.

___ General Medical Information	___ Psychiatric Information
___ Financial Information	___ Drug/Alcohol Abuse
___ HIV Testing/Treatment	___ Labs/Diagnostic Testing

Patient Name

Signature of Patient or Legal Guardian

Date