



ENT Associates, Inc.

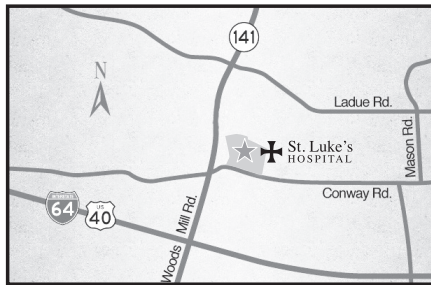
A division of **SOUNDHEALTH SERVICES**

Norman S. Druck, M.D., F.A.C.S.
Richard W. Maack, M.D., F.A.C.S.
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Matthew A. Marino, M.D., MPH
Lisa M. Mantia, FNP, BC
Kristen Wilber, FNP, BC

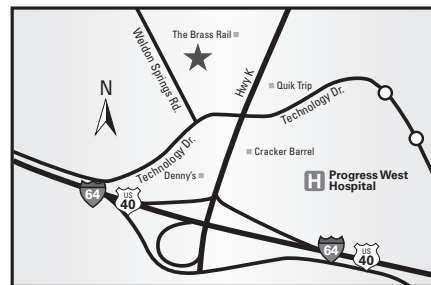
Dear _____

Thank you for scheduling an appointment with ENT Associates, Inc. located at:

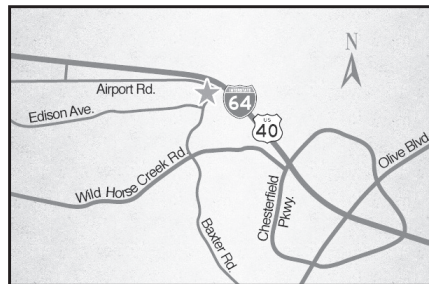
St. Luke's Hospital
226 S. Woodsmill Rd, Suite 37W
Chesterfield, MO 63017



4651 Highway K
O'Fallon, MO 63368



Synergi Facial Surgery
17000 Baxter Rd, Suite 102
Chesterfield, MO 63005



SEE ADDITIONAL DIRECTIONS ON BACK SIDE

Please complete the enclosed forms and bring them with you for your appointment on _____, _____ at _____ am/pm.

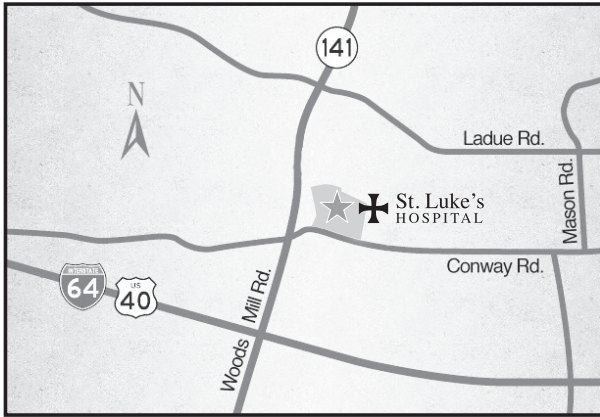
Remember to bring your insurance card, co-payment and referral if needed from your primary doctor. If you have any CT scans, the report and office notes, please bring those along.

If you have an HMO, you may also have the referral faxed to us listed below.

**ADULT & PEDIATRIC EAR, NOSE & THROAT • HEAD & NECK SURGERY • ALLERGY
FACIAL PLASTIC SURGERY • VOICE MEDICINE • AUDIOLOGY • HEARING SERVICES**

226 S. Woods Mill Road, Suite 37W • Chesterfield, MO. 63017 • (314)523-5300 • Fax (314)434-3191
17000 Baxter Road, Suite 102 • Chesterfield, MO. 63005 • (314)523-5330 • Fax (636)532-0035
4651 Highway K • O'Fallon, MO. 63368 • (314)523-5300 • Fax (636)561-1180
Exchange: (314)388-6265 www.ent-stl.com

St. Luke's Hospital
226 S. Woodsmill Rd, Suite 37W
Chesterfield, MO 63017



Directions from St. Louis:

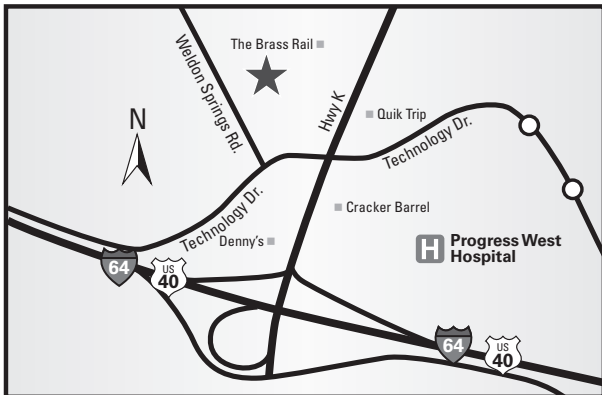
Take Hwy 40 West to Exit 22 (MO-141/Woods Mill Rd). Merge onto North Outer 40 Road. Merge onto MO-141 North. Make a right turn at (2nd Stoplight) entering the St. Luke's Hospital Complex. Enter West parking garage (1st Bldg. on right). We are located on the yellow level of garage, which is the 3rd floor of the West Medical Building.

Directions from St. Charles:

Take Hwy 40 East to Exit 22 (MO-141/Woods Mill Rd). At stoplight, make a left onto MO-141/Woods Mill Rd. Make a right turn at (3rd Stoplight) entering the St. Luke's Hospital Complex. Enter West parking garage (1st Bldg. on right). We are located on the yellow level of garage, which is the 3rd floor of the West Medical Building.

*Valet Parking is available at front door of West Medical Building.

4651 Highway K
O'Fallon, MO 63368



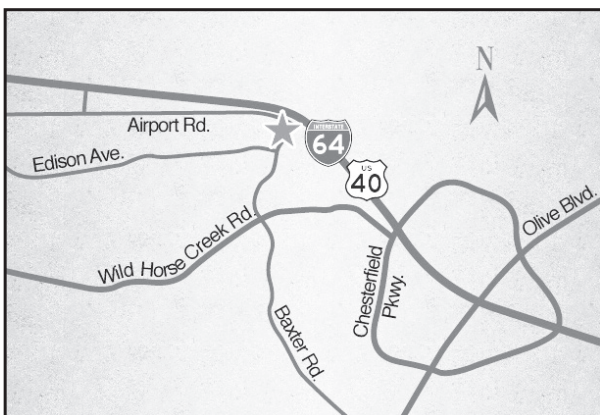
Directions from Hwy 40:

Take Exit 9 toward Highway K, O'Fallon. At light take a left onto Technology Drive. Take first right onto Weldon Springs Road, and first right again into the strip mall area, entering by Advanced Bone and Joint Building. We are located next to Friar Tuck.

Directions from St. Charles / St. Peters:

Take Highway 70 to exit 94 West. Follow 94 West, continue on 364 West to Exit 4 for Highway K. Turn left off exit ramp, and follow Highway K for 2.8 miles. Just past Crusher Road, take a right at the Starbucks. Proceed to the strip mall area. We are located next to Friar Tuck.

Synergi Facial Surgery
17000 Baxter Rd, Suite 102
Chesterfield, MO 63005



Directions from St. Louis:

Take Hwy 40 West to Exit 17-Boone's Crossing. Make a left over the overpass. Make a left at the 2nd stoplight onto Chesterfield Airport Road. Make a right at the 4th stoplight - about 1 mile to Baxter Road. We are the 2nd building on your right. "Synergi"

Directions from Saint Charles:

Take Hwy 40 East to Exit 17-Boone's Crossing. Make a right and merge into the left lane. Turn left onto Chesterfield Airport Road. Make a right at the 4th stoplight - about 1 mile to Baxter Road. We are the 2nd building on your right. "Synergi"



Medical History Questionnaire

Patient Name _____ Age _____ Date of Birth _____ Date _____

Primary Care Physician _____ Referring Physician _____

Today's appointment with: Dr. Druck Dr. Maack Dr. Dahm Dr. Park
 Dr. Lima Dr. Marino Lisa Mantia Kristen Wilber

Nature of Visit:

____ First visit, A consultation was requested by Doctor _____ (Please list doctor's name)
____ First visit, Referred by _____
____ This is a follow-up visit

- **Chief Complaint** (Reason for today's visit) _____
- **History of Present Illness:** (Describe the signs/symptoms that you have, when they started, and how they have changed)
 - Location (Where is the problem?) _____
 - Quality: (Dull, Throbbing, Sharp) _____
 - Severity: (Mild, Moderate, Severe) _____
 - Timing: (Daily, With activity, At night) _____
 - Duration (How long does it last?) _____
 - Associated signs & symptoms _____
 - Modifying factors (What makes it better or worse?) _____

• **Had Pneumonia Vaccine** _____ Yes _____ No, if Yes, date of last vaccine _____

• **Flu Vaccine** _____ Yes _____ No, if Yes, date of last vaccine _____

• **Do you currently take ANY medications** _____ Yes _____ No, if Yes, please list **Name, Dosage and Frequency:**

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Drug Allergies	No	Yes	if yes, please list name of Drug _____	Reaction: _____
Latex Allergy	No	Yes		

• **Past Medical History** (Have you been diagnosed with any of the following? Please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer Type _____ | <input type="checkbox"/> Kidney Disease
Specify _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV | <input type="checkbox"/> COPD |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding problems
Specify _____ | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Trouble
Specify _____ | <input type="checkbox"/> Autism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes, <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Thyroid disorder, <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper | <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> STD
Specify _____ | <input type="checkbox"/> Nervous / Psych disorder
Specify _____ | <input type="checkbox"/> Autoimmune disorder
Specify _____ |
| <input type="checkbox"/> Hepatitis, <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | | <input type="checkbox"/> Genetic Disorder
Specify _____ |
| <input type="checkbox"/> Gastric Reflux | | <input type="checkbox"/> Allergy |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> No Past Medical History |

• **Past Surgical History:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Chemo or Radiation Therapy | <input type="checkbox"/> Neck Surgery
Specify _____ |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Transplant Surgery
Specify _____ | <input type="checkbox"/> Sinus Surgery
Specify _____ |
| <input type="checkbox"/> Breast Surgery
<input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Ear Tubes, <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Nasal |
| <input type="checkbox"/> Heart Surgery
Specify _____ | <input type="checkbox"/> Ear Surgery
Specify _____ | <input type="checkbox"/> Adenoidectomy |
| <input type="checkbox"/> Hysterectomy | | <input type="checkbox"/> Tonsillectomy |

Surgery not listed above: _____ **No Past Surgical History**

Please Continue On Back Side



Account # _____

• **Social History**

Occupation _____ **Marital Status** _____
Environmental Exposure: Dust _____ Fumes _____ Solvents _____ Noise _____

Smoking/Tobacco History

- Never
- Former Smoker # years smoked _____ # per day _____ Date Quit _____
Type: Cigarette Cigar E-Cigarette/Vape Snuff/Chew Other _____
- Current Smoker # per day _____ Date started _____ How long? _____
Type: Cigarette Cigar E-Cigarette/Vape Snuff/Chew Other _____

Do you drink Alcohol?

- Never
- Rarely
- No, I quit ___ years ago. I was drinking ___ drinks per day / week / month (circle one) for ___ years.
- Yes, I have ___ drinks per day / week / month (circle one). List type of alcohol: _____

• **Review of Current Symptoms:** (Check any of the following that apply to you.)

- | | | | | | | |
|--|--|---------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|---|
| <u>Constitutional</u> | <u>Eyes</u> | <u>ENT</u> | <u>Cardiovascular</u> | <u>Respiratory</u> | <u>Gastrointestinal</u> | <u>GU</u> |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vision change | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of | <input type="checkbox"/> Nausea | <input type="checkbox"/> Freq/urinate |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Glasses | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Foot/Ankle | Breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Pain/urinate |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Contacts | <input type="checkbox"/> Sore throat | Swelling | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Fatigue | | <input type="checkbox"/> Hoarseness | | <input type="checkbox"/> Snoring | <input type="checkbox"/> Heart Burn | |
| | | <input type="checkbox"/> Nose Bleeds | | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Ulcers | |
| <u>Musculoskeletal</u> | <u>Skin</u> | <u>Neurology</u> | <u>Psychiatry</u> | <u>Endocrine</u> | <u>Hematology</u> | <u>Allergy</u> |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Numbness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Heat | <input type="checkbox"/> Swell/lymph | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Muscle Weakness | | <input type="checkbox"/> Headache | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cold | <input type="checkbox"/> Blood | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Joint Pain | | <input type="checkbox"/> Slurring | <input type="checkbox"/> Depression | | Transfusion | <input type="checkbox"/> Food |
| | | <input type="checkbox"/> Seizures | | | | <input type="checkbox"/> Congestion |

• **Family Medical History:** (Do any family members have any of the medical problems listed below?) Check all that apply
Example: Mother = M, Father = F, Grandmother = GM, Grandfather = GF, Brother = B, Sister = S, Aunt = A, Uncle = U

- | | | | |
|--|---------------------------|---|---------------------------|
| <input type="checkbox"/> Heart Trouble | Relationship _____ | <input type="checkbox"/> High Blood Pressure | Relationship _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Kidney | _____ | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Liver Disease | _____ | <input type="checkbox"/> Stroke or TIA | _____ |
| <input type="checkbox"/> Bleeding Tendencies | _____ | <input type="checkbox"/> Nervous / Psychiatric Disorder | _____ |
| Specify _____ | | Specify _____ | |
| <input type="checkbox"/> Gastric Reflux | _____ | | |
| <input type="checkbox"/> Hearing Loss | _____ | <input type="checkbox"/> Other _____ | |
- No Known Family History

PLEASE SIGN:

Patient or Responsible Party Signature: _____



Vital Signs: Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

Physician Signature _____ **Date** _____



PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
 Date of Birth: _____ Sex: _____ SS Number: _____ Marital Status: S M D W
 Language: English, Bosnian, French, German, Mandarin, Spanish, Vietnamese, Italian, Decline
 Race: African American, American Indian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial,
 Native American, Declined
 Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Declined
 Home Number: _____ Work Number: _____ Mobile Number: _____
 Preferred Phone Contact: Home, Mobile, Work OK to Receive Text Messages: Yes or No
 Email Address: _____
 Home Address: _____
 City: _____ State: _____ Zip Code: _____
 Preferred Local Pharmacy: _____ Phone Number: _____
 Referring Physician: _____ Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber/Policy Number: _____
 Last Name: _____ First Name: _____ MI: _____
 Date of Birth: _____ Sex: _____ Relationship to Patient: _____
 Billing Address (if different from above): _____
 Home Number: _____ Mobile Number: _____

Secondary Insurance: _____ Subscriber/Policy Number: _____
 Last Name: _____ First Name: _____ MI: _____
 Date of Birth: _____ Sex: _____ Relationship to Patient: _____
 Billing Address (if different from above): _____
 Home Number: _____ Mobile Number: _____

FINANCIALLY RESPONSIBLE PARTY (Person Bringing Child In)

Last Name: _____ First Name: _____ MI: _____
 Date of Birth: _____ Sex: _____ Relationship to Patient: _____
 Billing Address (if different from above) _____
 Home Number: _____ Mobile Number: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature: _____ **Date:** _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to \$35 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER to be set up as a “Self-Pay” patient. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day’s services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of \$5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
- **FMLA AND/OR WORKMAN COMP** – There is a \$25.00 charge for completion of Workman Comp or FMLA forms.
- **SURGERY DEPOSITS** – If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.
- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan’s UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not “participate” with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician’s office.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.
- **INSUFFICIENT FUND CHECKS** – A \$25.00 fee will be charged to patient’s account for checks returned due to non sufficient funds
- You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, an additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient’s Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I understand that Sound Health Services, P.C. (the "Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers

_____ .

I authorize Sound to report any test results on any telephone answering device or service which may answer the telephone number I inserted in the preceding paragraph.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.
Attn: Privacy Officer
3860 South Lindbergh
St. Louis, MO 63127

Signature of Patient/Patient's Representative

Date:

Basis of representative's authority to act for patient: _____
