

Ear, Nose & Throat – Head and Neck, Surgery, P.C.  
Thomas J. Dobleman, M.D., F.A.C.S.  
Douglas C. Larsen PA-C  
11704 W. Center Road, Ste 211 • Omaha, NE 68144  
Office (402)393-7050 • Fax (402)393-2814  
Email • entomaha@gmail.com

Dear Patient,

Welcome to our practice! We are pleased that you have chosen us for your medical needs and appreciate your trust.

Office visits are by appointment only. We will try to make yours as convenient as possible. Because of the many emergencies in our practice, we may be delayed or may even have to reschedule your appointment. We apologize in advance for any inconvenience this may cause.

Enclosed are our New Patient information forms. We ask that you take the time to fill these out before your first visit. **Please complete all the forms. Don't forget to sign and date where it is indicated.**

**We also ask that you bring all insurance cards and a driver's license.** We will need to make copies of your card and keep it with your records. Co-payments are required and collected at the time of visit. As a courtesy to our patients, we file your insurance; however, **it is the patient's responsibility to confirm their insurance coverage and benefits.**

Patients with an HMO insurance are required to have any referral forms at the time of their visit. If you have a referral form, we also ask that you bring that to your appointment. Without a referral, the patient can either reschedule the appointment or pay for the services incurred at that time.

Thank you for your cooperation,

Thomas J. Dobleman, M.D., FACS

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**PATIENT INFORMATION – Please complete all fields**

Patient \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M. Initial \_\_\_\_\_

D.O.B \_\_\_\_\_ SS# \_\_\_\_\_ - - \_\_\_\_\_ Gender  M  F

Marital Status  S  M  D  W  O RACE \_\_\_\_\_

Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Patient's  
Employer \_\_\_\_\_ Phone \_\_\_\_\_

Student status  Full time  Part time School \_\_\_\_\_

If Married  
Spouse's Name \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone \_\_\_\_\_

*Please check box to indicate your preferred contact number*

I give my permission to leave a detailed message regarding my appointment time, changes of, or scheduling information on my voice mail, with a family member, or person answering the phone.  Yes  No

I give my permission to leave test results on my voice mail.  Yes  No

Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Minor's  
Mother Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Father Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referred by \_\_\_\_\_

In case of Emergency, whom may we contact? Please list below

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Communication preferences regarding PHI**

To assist in your care, it may be necessary to release your **Protected Health Information** to someone other than yourself. Please list below who we may talk to (spouse, parent, guardian, caregiver, etc...)

\_\_\_\_\_  
\_\_\_\_\_

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**Insurance Information – failure to complete all fields may prevent us from filing claim on your behalf**

**Primary Insurance**

Insurance Name \_\_\_\_\_

Id # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder D.O.B. \_\_\_\_\_

Policy Holder S.S.# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Secondary Insurance**

Insurance Name \_\_\_\_\_

Id # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder D.O.B \_\_\_\_\_

Policy Holder S.S.# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Assignment of Benefits and HIPPA Notice**

**Dr. Thomas Dobleman, MD, FACS and Doug Larsen PA-C feel that patients presenting to our office with sinus, allergy, throat and hearing or voice complaints require a thorough examination of the specific area. In some cases, this can only be accomplished through the use of diagnostic test or procedures. The following is a list of the test/procedures that may be performed or ordered:**

Audiogram (Hearing test)

Laryngoscopy, Nasal Endoscopy/Rhinoscopy

Sinus cleaning (“debridement”) after sinus surgery

Tympanogram

Sinus X-ray

Minor Surgical procedures and biopsies

**The following procedures are often considered surgical procedures by insurance companies and may be applied to your deductible or coinsurance:**

Laryngoscopy

Nasal Endoscopy

Removal Impacted Cerumen

Sinus cleaning (“debridement”) after sinus surgery

Minor Surgical procedures and biopsies

Chemical Cautery

**Assignment of Benefits:**

I acknowledge financial responsibility for all facility and physician/provider(s) fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payment made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge responsibility for all charges if inaccurate insurance information is given at time of service and the information is not correct prior to my insurance company’s timely filing limit.

Date

Signature

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Medical History

Patient \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M. Initial \_\_\_\_\_

D.O.B. \_\_\_\_\_ Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Reason for Today's visit?

Please indicate (x) if you have any of the following medical conditions:

- |                   |                          |                                |                          |                  |                          |
|-------------------|--------------------------|--------------------------------|--------------------------|------------------|--------------------------|
| Hypertension      | <input type="checkbox"/> | Sinusitis                      | <input type="checkbox"/> | Stroke           | <input type="checkbox"/> |
| High Cholesterol  | <input type="checkbox"/> | Bleeding Tendencies            | <input type="checkbox"/> | Diabetes Type I  | <input type="checkbox"/> |
| Kidney Disease    | <input type="checkbox"/> | Lung Disease (COPD)            | <input type="checkbox"/> | Diabetes Type II | <input type="checkbox"/> |
| Thyroid Disease   | <input type="checkbox"/> | Asthma                         | <input type="checkbox"/> | Pneumonia        | <input type="checkbox"/> |
| Joint replacement | <input type="checkbox"/> | Heart Disease                  | <input type="checkbox"/> | HIV              | <input type="checkbox"/> |
| Blood Clots (DVT) | <input type="checkbox"/> | Seasonal allergies             | <input type="checkbox"/> | Hepatitis        | <input type="checkbox"/> |
| Tuberculosis      | <input type="checkbox"/> | Arthritis                      | <input type="checkbox"/> | Osteoporosis     | <input type="checkbox"/> |
| Anxiety           | <input type="checkbox"/> | Gastrointestinal (acid reflux) | <input type="checkbox"/> | Seizures         | <input type="checkbox"/> |
| Cancer            | <input type="checkbox"/> |                                |                          |                  |                          |

Please explain: \_\_\_\_\_

Other, please explain: \_\_\_\_\_

Please indicate if a family member has a history of the following disease/disorders:

- |                     | Relationship                   |                  | Relationship                   |
|---------------------|--------------------------------|------------------|--------------------------------|
| Hypertension        | <input type="checkbox"/> _____ | Asthma           | <input type="checkbox"/> _____ |
| High Cholesterol    | <input type="checkbox"/> _____ | Heart Disease    | <input type="checkbox"/> _____ |
| Kidney Disease      | <input type="checkbox"/> _____ | Arthritis        | <input type="checkbox"/> _____ |
| Thyroid Disease     | <input type="checkbox"/> _____ | Gastrointestinal | <input type="checkbox"/> _____ |
| Joint Replacement   | <input type="checkbox"/> _____ | Stroke           | <input type="checkbox"/> _____ |
| Blood Clots (DVT)   | <input type="checkbox"/> _____ | Diabetes         | <input type="checkbox"/> _____ |
| Tuberculosis        | <input type="checkbox"/> _____ | Hepatitis        | <input type="checkbox"/> _____ |
| Bleeding Tendencies | <input type="checkbox"/> _____ | Osteoporosis     | <input type="checkbox"/> _____ |
| Lung Disease (COPD) | <input type="checkbox"/> _____ | Seizures         | <input type="checkbox"/> _____ |
| Cancer              | <input type="checkbox"/> _____ | Type:            | _____                          |

Other, please explain: \_\_\_\_\_

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If female, are you pregnant?		If yes, how far along?	
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Any other medical conditions that we should be aware of?			

Surgical history and or surgical complications?			

Are you allergic to latex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you allergic to medical tape?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any known drug allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

If yes, please list all medications you are allergic to below"

Medication patient is <b>ALLERGIC</b> to	Reaction (please circle)					
	Itching	Hives	Anaphylaxis	Swelling	Nausea	Vomiting
	Other:					
	Itching	Hives	Anaphylaxis	Swelling	Nausea	Vomiting
	Other:					
	Itching	Hives	Anaphylaxis	Swelling	Nausea	Vomiting
	Other:					

**Social History**

Patient occupation? \_\_\_\_\_ Children  No  Yes Live Alone  No  Yes

Tobacco use?  Never  In the past  Presently How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Alcohol use?  Never  Daily  Occasional Has patient ever been treated or diagnosed with alcoholism?  No  Yes

Recreational Drug use?  No  Yes If yes, what recreation drugs are being used? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_ How long? \_\_\_\_\_

Has the patient ever been treated or diagnosed with drug addiction?  No  Yes

Current Medications Name	Dose/strength	How Often?	Reason?

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