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	☐	Sinusitis	☐	Stroke	☐
High Cholesterol	☐	Bleeding Tendencies	☐	Diabetes Type I	☐
Kidney Disease	☐	Lung Disease (COPD)	☐	Diabetes Type II	☐
Thyroid Disease	☐	Asthma	☐	Pneumonia	☐
Joint replacement	☐	Heart Disease	☐	HIV	☐
Blood Clots (DVT)	☐	Seasonal allergies	☐	Hepatitis	☐
Tuberculosis	☐	Arthritis	☐	Osteoporosis	☐
Anxiety	☐	Gastrointestinal (acid reflux)	☐	Seizures	☐
Cancer	☐				

Please explain: _____

Other, please explain: _____

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

		Relationship			Relationship
Hypertension	☐	_____	Asthma	☐	_____
High Cholesterol	☐	_____	Heart Disease	☐	_____
Kidney Disease	☐	_____	Arthritis	☐	_____
Thyroid Disease	☐	_____	Gastrointestinal	☐	_____
Joint Replacement	☐	_____	Stroke	☐	_____
Blood Clots (DVT)	☐	_____	Diabetes	☐	_____
Tuberculosis	☐	_____	Hepatitis	☐	_____
Bleeding Tendencies	☐	_____	Osteoporosis	☐	_____
Lung Disease (COPD)	☐	_____	Seizures	☐	_____
Cancer	☐	_____ Type:			_____

Other, please explain: _____

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If female, are you pregnant?		If yes, how far along?	

Any other medical conditions that we should be aware of?

Surgical history and or surgical complications?

Are you allergic to latex?	☐ No	☐ Yes
Are you allergic to medical tape?	☐ No	☐ Yes
Do you have any known drug allergies?	☐ No	☐ Yes

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

Medication patient is **ALLERGIC** 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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