**Dennis Lee, MD, MPH, SC**
107 North Regency Drive
Bloomington, IL 61701

**Patient Information** – Please print clearly

Patient Name: _____Date of Birth: _____/_____/_____ Age: _____
Last First MI

Please circle one: Male Female Please circle one: Single Married Divorced Widowed Separated

Home Address: _____ _____ _____ _____
City State Zip Code

Home Phone: (_____) _____ - _____ **Employment Info:** Full time Part Time Unemployed Student
Cell Phone: (_____) _____ - _____ Employer Name: _____
Work Phone: (_____) _____ - _____ Employer Address: _____

**Emergency Contact:** _____ **Relationship:** _____
Emergency Contact Phone: (_____) _____ - _____
**Name of Responsible Party:** _____**Relationship:** _____
Address of insured/responsible party: _____
Phone # of insured/responsible party: (_____) _____ - _____ D.O.B of insured/responsible party: _____

**Reason for Visit:** (Please give a detailed description of symptoms/problems you have been having.)
_____

_____

**Referring Doctor:** _____ **Primary Care Doctor:** _____
Ref Doctor Ph#: (_____) _____ - _____ Primary Doctor Ph#: (_____) _____ - _____

## Insurance Information:

Primary Insurance: _____ Is Referral Required? Yes No
Policy Holder Name: _____ Relation to Patient _____
Policy Holder Date of Birth: _____/_____/_____ Policy Holder Ph#: (_____) _____ - _____
Policy Holder Address: _____
Is this a Group Insurance Policy? Yes No If yes, Employer Name: _____

Secondary Insurance: _____ Is Referral Required? Yes No
Policy Holder Name: _____ Relation to Patient _____
Policy Holder Date of Birth: _____/_____/_____ Policy Holder Ph#: (_____) _____-_____
Policy Holder Address: _____
Is this a Group Insurance Policy? Yes No If yes, Employer Name: _____

**Authorization of Treatment/Insurance Release of Information/Assignment of Benefits**

- I hereby authorize Dennis Lee, MD, MPH, to release to my insurance company(s) or its representatives, any information, including the diagnosis and records of any treatment or examination rendered to me/my dependent during the period of such medical and/or surgical care.
- I also authorize and request that payment be made directly to Dennis Lee, MD, MPH for the amount due for pending claim for basic medical, major medical, and/or surgical treatment or services by reason of such treatment or services rendered.
- I affirm that the information I have given is correct to the best of my knowledge.
- I authorize treatment of the person named as patient. I understand that medical and nursing students may be involved in my/patient's care. I understand that I am responsible for payment of my/patient's account, including all deductibles, copays, and coinsurance. Estimated out of pocket amounts are due at the time that services are rendered.
- I further acknowledge that I am responsible for any and all charges incurred that may or may not be covered by my insurance plan and accept responsibility for such charges. If account is referred for collection to an outside agency, I will be responsible for any interest and/or collection fees.

Signature of patient/responsible party: _____ Rel to Patient: _____

Today's date: _____

Please note that in order to maintain current records, you may be asked to complete this form annually.

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**Patient Medical History:** (Please print clearly)

_____ Date of Birth: _____/_____/_____
Last Name First MI

**Medical History**

**Drug Allergies:** (Please Circle One) **Yes No**

| Drug Name | Reaction |
|---|---|
| | |
| | |
| | |
| | |

Please list any medications that cause you unpleasant side effects that you prefer not to take:

_____

_____

Are you allergic to any of the following?

| | | |
|---|---|---|
| Bee/Wasp Stings | Yes | No |
| Iodine/Xray Contrast | Yes | No |
| Latex/Rubber | Yes | No |
| Adhesive Tape | Yes | No |

**Current Medications:**

| Name | Dose | How Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list any *recently* used medications:

_____

_____

Have you taken Aspirin/Motrin/Ibuprofen or similar drugs in the past 2 weeks? Yes No

Have you taken Cortisone type drugs? Yes No

Do you smoke/vape? Yes No How much? _____
Do your drink alcohol? Yes No How much? _____
Do you use caffeine? Yes No How much? _____
Do you use street drugs? Yes No Which? _____

List any FOOD allergies: _____

What is your preferred pharmacy? _____ Pharmacy Ph# (_____) _____ - _____

**Personal Medical History**: Have you had any of these problems in the past 18 months? (Please mark any problem with an "X")

| | | | | |
|---|---|---|---|---|
| Change in weight _____ | Blood in sputum _____ | Hearing Loss _____ | Nausea/vomiting _____ | Alcohol/Drug Abuse _____ |
| Persistent fever _____ | Itchy/waxy ears _____ | Stuffy nose/sinus ____ | Peptic ulcer _____ | Chronic Cough _____ |
| HIV/AIDS _____ | Draining ears _____ | Freq. Nosebleed _____ | Shortness of breath ____ | Bleeding Problems _____ |
| Cancer _____ | Neck stiff/pain _____ | Voice change _____ | Thyroid problems _____ | Poor Healing _____ |
| Blurred vision _____ | Ear pain _____ | Sore throat/mouth ___ | Migraine headache ____ | Anemia _____ |
| Eye pain _____ | Ear Noise _____ | Lump in neck _____ | Head injury _____ | Dizziness/Vertigo _____ |
| Seizures _____ | Stroke _____ | Heart attack _____ | Diabetes _____ | Heart palpitations _____ |
| High blood pressure ___ | Asthma/Emphysema ___ | Mitral valve prolapse _____ | | |

**History of Hospitalizations and/or Surgeries. Please list reason for hospitalization, type of surgery, and year.**

_____

_____

_____

**Family History:** Please indicate if there is a relative who has/had any of the following and their relationship to the patient.

| | | | |
|---|---|---|---|
| High Blood Pressure: | Yes No | Relationship: _____ | **Mother's Name: _____** |
| Diabetes: | Yes No | Relationship: _____ | |
| Stroke/Heart Attack: | Yes No | Relationship: _____ | **Father's Name: _____** |
| Thyroid problems: | Yes No | Relationship: _____ | |
| Cancer: | Yes No | Relationship: _____ | **Siblings' Names: _____** |
| Heart disease: | Yes No | Relationship: _____ | _____ |
| Renal disease: | Yes No | Relationship: _____ | _____ |
| Psychiatric: | Yes No | Relationship: _____ | |
| Other: _____ | Yes No | Relationship: _____ | Today's Date: _____ |

**Dennis Lee, MD, MPH, SC**
107 North Regency Drive
Bloomington, IL 61701
Ph: 309-662-4411 Fax: 309-663-1533

## Patient Privacy

Completing this form will assist our office by authorizing us to share your medical and/or billing information with persons you designate.

Patient Name: _____ Patient Date of Birth: _____

*******Whether the patient is an adult or child, the following must be completed*******

### Medical Authorization

I, _____, authorize medical information to be shared with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**I, _____, do not authorize any medical information to be shared.**

### Billing Authorization

**Please authorize the insured or any other person who may call on behalf of the patient to discuss claims and/or balance on account.** (Note: The insured member will receive Explanation of Benefits if insurance is billed. *If you do not want the insured member to be aware of your visit, we will not bill insurance. You will be considered self-pay and payment for the entire balance will be collected at the time of service. No provider discounts will be applied.*)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If the patient is a minor, please inform the office of any legal guardianship or court appointed child custody arrangement *(**PLEASE PROVIDE LEGAL DOCUMENTATION**)*:

Legal Guardian: _____ Address: _____

Phone: _____

Legal Guardian: _____ Address: _____

Phone: _____

### HIPAA Privacy Notice

I, _____, acknowledge that I have received a copy of the office's Privacy Notice.
(Patient or Personal Representative)

Form completed by: (please print legibly) _____ Relationship: _____

Signature: _____ Date: _____

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# INFORMED CONSENT FOR TELEPHONE EVALUATION AND MANAGEMENT

Patient Name: _____ Date of Birth: _____

Telephone evaluation and management services provided by a physician or other qualified health care professional to an established patient, parent, or guardian may assist in the diagnosis, therapy, follow-up and/or education may be necessary from time to time.

Benefits of telephone evaluation and management include:

- Live two-way audio communication
- Access to results and/or pathology
- Remote evaluation or follow-up care when condition warrants
- Ability to maintain quarantine status when applicable for the safety of patient and/or office personnel

As with any medical procedure, there are potential risks associated with the use of telephone evaluation. These risk include, but may be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor connection to allow for appropriate medical decision making by the physician or for interpretation by patient, parent, or guardian)
- Equipment failure
- In very rare cases, security protocols could fail, causing a breach of privacy of personal medical information

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telephone evaluation and management.
- I understand that I have the right to withhold or withdraw my consent to the use of telephone evaluation and management without affecting my right to future care or treatment.
- I understand that I may expect anticipated benefits from telephone evaluation and management, but that no results can be guaranteed or assured.
- I understand that there is a fee associated with telephone evaluation and management and that my insurance will be billed for these services.
- I acknowledge that I am responsible for any and all charges incurred that may or may not be covered by my insurance plan and accept responsibility for such charge. If my account is referred for collection to an outside agency, I will be responsible for any interest and/or collection fees.

I have read and understand the information provided and hereby give my informed consent for the use of telephone evaluation and management.

Signature of patient/responsible party: _____ Rel to Patient: _____

Today's Date: _____

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## Informed Consent
## ENDOSCOPY OF THE NOSE AND UPPER AIRWAY

**Patient Name: _____ Date of Birth: _____**

Patients presenting to our office with sinus, allergy, throat or voice complaints may require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This diagnostic examination is essentially painless and, in many cases, can be accomplished quickly with no anesthetic. These procedures have almost no risks and provide your physician with an excellent view of the areas involved. Rare complications may include: Bleeding, reaction to topical anesthesia, pain and coughing or shortness of breath.

Please be aware that certain endoscopic procedures performed in our office are not included in the standard office visit. These procedures will be billed separately in addition to the office visit charges and may be subject to your deductible and coinsurance as some insurance companies may list this diagnostic procedure as "surgery" on the explanation of benefits form that you receive.

Please sign below to acknowledge that you have read the above and agree to undergo the procedure as deemed necessary.

- Flexible Laryngoscopy 31575
- Nasopharyngoscopy 92511
- Nasal/Sinus Debridement 31237

This is a surgical procedure using a small endoscope to look through your nostrils to:

1. Examine nasal and sinus passages for nasal congestion, blockage, infection, polyps, tumors, nosebleeds
2. Obtain drainage for culture
3. Evaluate previous surgery, scar, openings
4. Evaluate healing or complications of surgery
5. Obtain specimens/biopsy for pathology evaluation
6. Remove old blood, foreign material, packing, scabs/scar/blockage

**AUTHORIZATION TO PERFORM PROCEDURE:**

_____ _____
Patient Name Date

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date