Newburyport Medical Center
1 Wallace Bashaw Jr. Way, Suite 3002
Newburyport, MA 01950
P: 978.997.1550
F: 978.688.8292

200 Sutton Street, Suite 100
North Andover, MA 01845
P: 978.685.2900

Merrimack Medical Center
62 Brown Street, Suite 301
Haverhill, MA 01830
P: 978.521.0300

Daryl Colden, MD, FACS
Board Certified
Otolaryngology – Head & Neck Surgery
Facial Plastic & Reconstructive Surgery
Fellowship Trained
Advanced Nasal & Facial Plastic Surgery
Fellow
American Academy of Otolaryngic Allergy
Clinical Instructor in Otology & Laryngology
Harvard Medical School
Assistant Surgeon in Otolaryngology
Massachusetts Eye & Ear Infirmary
Assistant Clinical Professor
Otolaryngology Head & Neck Surgery
Tufts Medical School

Peter Seymour, MD
Board Certified
Otolaryngology – Head & Neck Surgery
Fellowship Trained
Otologic Medicine & Surgery
(Ear & Balance Disorders)
Associate
American Academy of Otolaryngic Allergy
Assistant Surgeon in Otolaryngology
Massachusetts Eye & Ear Infirmary
Assistant Clinical Professor
Otolaryngology – Head & Neck Surgery
Tufts Medical School

Elizabeth Mahoney Davis, MD, FACS
Board Certified
Otolaryngology – Head & Neck Surgery
Fellow
American Academy of Otolaryngic Allergy
Assistant Professor
Otolaryngology – Head & Neck Surgery
Boston University School of Medicine

Renee Llorente, MA CCC-A
Sarah Wellwood, AuD CCC-A
Pediatric & Adult Audiology
Hearing Aid Evaluation
Aural Rehabilitation

Donna Cardarelli
Office Manager

Hospital Affiliations
Anna Jaques Hospital
Merrimack Valley Hospital
Holy Family Hospital

Surgical Center Affiliations
Andover Surgical Center
Stratham Surgical Center

Academic Affiliations
Massachusetts Eye & Ear Infirmary
Tufts Medical Center
Boston University School of Medicine

www.ColdenSeymourENT.com

COLDEN SEYMOUR

EAR NOSE THROAT & ALLERGY

Adult & Pediatric Care / Hearing & Balance Center
Sinus & Sleep Specialists / Facial Plastic Surgery

Patient_____

Date of Birth _____

Marital Status M S W

Race: _____ **Ethnicity**: _____ **Language**:_____

If Minor name of Parent or Guardian_____ **Relationship**_____

Address_____
Street

_____
City State Zip

Home Phone_____**cell**_____**work**_____

Address/Phone of Guardian or Parent if different from above_____

Name of emergency contact: _____**Phone** _____**Relationship**_____

Primary Care Physician _____**phone/address** _____

Referring physician (if different) _____

Pharmacy _____ _____ _____
Name City state

Patient employer & address_____

Occupation:_____

Name of primary insurance_____**Subscriber's name** _____

Name of secondary insurance _____ **Subscriber's name** _____

Work Related Injury: Y N *If yes, please complete workmen's compensation information form.*

How did you find out about this practice? _____

Please list your email address?_____

I, the undersigned, have insurance coverage with _____and assign directly to Colden & Seymour Ear Nose Throat & Allergy medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. If my insurance requires a referral and I do not secure one, I will be responsible for payment.

Signature:_____Date:_____
(patient signature or signature of parent/guardian if patient is a minor under 18)

PATIENT_____ DOB_____

Height: _____ Weight: _____

Pharmacy: _____

Patient Medical Intake Form and Medical History- Colden & Seymour Ear, Nose, Throat & Allergy

QUESTIONS ABOUT YOUR CURRENT VISIT:

What is the reason for your visit today?_____

Have you had any RECENT testing such as MRI, CT scan, X-ray or lab work which is related to your reason for your visit today?

If YES, please state type of test: _____ Where: _____ When: _____

If you are female, is it possible that you are currently pregnant? O YES O NO

Have you ever had a hearing test?

If YES, please state WHEN _____ WHERE _____

QUESTIONS ABOUT YOUR SLEEP:

Have you ever been diagnosed with SLEEP APNEA? O YES O NO

Have you ever had a SLEEP STUDY O YES O NO

If YES, please state where _____

Do you currently use a CPAP machine? O YES O NO

Have you ever tried or used a CPAP machine in the past? O YES O NO

CURRENT MEDICATIONS: Are you currently taking any medications? O YES O NO If yes please list below *OR* attach list to this form:

Name of Medicine(s) - please include non-prescription	Name of Medicine(s) - please include non-prescription

MEDICAL HISTORY

Are you presently or have you been diagnosed with any of the following:

High blood pressure	O YES O NO	COPD/emphysema	O YES O NO	Heart attack	O YES O NO
Hearing loss	O YES O NO	Angina	O YES O NO	Eczema	O YES O NO
Diabetes	O YES O NO	Headaches/migraine	O YES O NO	Asthma	O YES O NO
HIV/AIDS	O YES O NO	Acid Reflux (GERD)	O YES O NO	Thyroid disease	O YES O NO
Allergic Rhinitis	O YES O NO	Epilepsy	O YES O NO	Bleeding disorders	O YES O NO
Hepatitis	O YES O NO	Hives	O YES O NO	Tonsillitis	O YES O NO
High cholesterol	O YES O NO	Anxiety	O YES O NO	Depression	O YES O NO
Cancer	O YES O NO	type: _____			

Is there any other medical history you want us to know about? _____

PATIENT_____ DOB_____-

Allergies to Medication

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Have you ever had an allergy test: O YES O NO
If YES, please state where: _____ and when: _____

Have you ever been treated with allergy shots or allergy drops (immunotherapy)?

O NEVER O CURRENTLY UNDER TREATMENT O TREATED IN THE PAST

Are you allergic to latex? O YES O NO

Have you ever had surgery? O YES O NO

If YES, lease list type and date of surgery below.

Type of Surgery and Date (Approximate)	Type of Surgery and Date (Approximate)

Have you been admitted to the hospital in the last six months? O YES O NO

If YES, please state WHEN _____ WHERE _____

FAMILY HISTORY Please check all that apply:

Father: O Alive O Deceased Age Deceased _____

Medical Issues: O Hearing loss O Asthma O Allergies O Heart disease O Stroke O Cancer type: _____

Mother: O Alive O Deceased Age Deceased _____

Medical Issues: O Hearing loss O Asthma O Allergies O Heart disease O Stroke O Cancer type: _____

Siblings: Number of brothers _____sisters _____

Medical Issues: O Hearing loss O Asthma O Allergies O Heart disease O Stroke O Cancer type _____

Children: Number of sons _____ daughters _____

Medical Issues: O Hearing loss O Asthma O Allergies O Heart disease O Stroke O Cancer type: _____

Is there any other family history you would like us to know about?

_____

PATIENT NAME: DOB:

SOCIAL HISTORY

Have you ever been exposed to excessive noise in the past? O YES O NO If YES, please explain _____
_____

Do you drink alcohol? O YES O NO -approximate servings per day _____

Do you have a history of prior heavy alcohol use? O YES O NO – approximate servings per day _____

Do you consume caffeine? O YES O NO – approximate servings per day _____

Do you use any other recreational drugs? O YES O NO details: _____

Are you a current or former smoker? O CURRENT O FORMER O NEVER SMOKED

How much do you/did you smoke? O ½ pack per day O 1 pack per day O 2 packs per day O Other: _____

When did you quit? _____ Number of years you smoked: _____

Do you or have you ever used chewing tobacco? O YES O NO O PREVIOUSLY USED

Are you exposed to any animals on a regular basis? O YES O NO

If YES, what type of animals?

_____

Please check the following that apply to your work and home environment:

O Old Home O New Home O Wooded area O Carpets O Hardwood
O Dusty home or work O Forced hot air O Wood Burning stove O Moldy environment

PATIENT _____- DOB _____-

REVIEW OF SYSTEMS – Please check all that apply TODAY

ALLERGY			GASTROENTEROLOGY		
Hay Fever	○ Yes	○ No	Vomiting	○ Yes	○ No
Hives	○ Yes	○ No	Heartburn/Acid Reflux	○ Yes	○ No
Food Allergy	○ Yes	○ No	Frequent Burping	○ Yes	○ No
UROLOGY	○ Yes	○ No	OPHTHALMOLOGY		
Recurrent Kidney Stones	○ Yes	○ No	Itchy Eyes	○ Yes	○ No
			Dry Eyes	○ Yes	○ No
ENT			Double Vision	○ Yes	○ No
Ear Infections	○ Yes	○ No	Watery eyes		
Hearing Loss	○ Yes	○ No			
Voice Change	○ Yes	○ No	CARDIOLOGY		
Nasal Congestion	○ Yes	○ No	Chest Pain	○ Yes	○ No
Nasal Discharge	○ Yes	○ No	Heart Palpitations	○ Yes	○ No
Difficulty Swallowing	○ Yes	○ No			
Snoring	○ Yes	○ No	HEMATOLOGY / LYMPHATIC		
Ear drainage	○ Yes	○ No	Enlarged Neck Glands	○ Yes	○ No
Ear pain	○ Yes	○ No	Easy Bruising	○ Yes	○ No
			Frequent Bleeding	○ Yes	○ No
RESPIRATORY			ENDOCRINOLOGY		
Shortness of Breath	○ Yes	○ No	Chronic Fatigue	○ Yes	○ No
Chronic cough	○ Yes	○ No	Thyroid Problems	○ Yes	○ No
			Diabetes	○ Yes	○ No
NEUROLOGY			SKIN		
Headache	○ Yes	○ No	Masses	○ Yes	○ No
Unsteady Gait	○ Yes	○ No	Rash	○ Yes	○ No
Seizures	○ Yes	○ No			
Dizziness	○ Yes	○ No			
MUSCULOSKELETAL			CONSTITUTIONAL		
Neck Pain	○ Yes	○ No	Chills	○ Yes	○ No
TMJ Tenderness	○ Yes	○ No	Fever	○ Yes	○ No
			Weight Loss	○ Yes	○ No
PSYCHOLOGY			Weight Gain	○ Yes	○ No
Depression	○ Yes	○ No	Speech Delay	○ Yes	○ No
Anxiety	○ Yes	○ No	Fatigue	○ Yes	○ No
Sleep Disturbances	○ Yes	○ No			

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1 Wallace Bashaw Jr. Way Suite 3002
Newburyport, MA 01950
Tel: 978-997-1550

Consent for Medical/Surgical Care/ Emergency Treatment And Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: _____for _____(patient name)
□ Mother □ Father □ Legal Guardian □ Son □ Daughter

hereby voluntarily consent to the rendering of such care, including diagnosis procedures, surgical and medical treatment, by authorized members of the office staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.
We/I hereby give our/my consent to _____

who will be caring for our/my child _____DOB: _____
(Name of Child)

for the period _____to _____ to arrange for routine or emergency medical care and treatment necessary to preserve the health of our/my child.

We/I acknowledge that we are/ I am responsible for all reasonable charges with the care and treatment rendered during this period.

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

In case of emergency, I can be reached at: _____

Consent to Discuss Medical Care and Treatment

I hereby authorize the office of Colden & Seymour Ear Nose Throat & Allergy to discuss my medical care and treatment with
Name: _____
□ Mother □ Father □ Spouse □ Other (please specify)

Patient Signature_____Date_____ DOB: _____ (patient must be 18 years or older)

Our Financial Policy

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.

* All patients must complete our "patient information forms" prior to seeing the doctor

* Full payment is due at the time of service (unless we have contracted with your insurance carrier and all appropriate referrals/authorizations have been issued). After full payment is made, you will receive an itemized receipt which you can submit for direct reimbursement.

* Your insurance carrier requires we collect designated copayment due at each and every visit. You are responsible for any deductible/coinsurance as indicated by your insurance plan. We reserve the right to collect these fees prior to rendering professional service (s), if applicable.

* During your evaluation, additional procedures may be done if medically necessary. These include hearing tests, allergy evaluation, wax removal, endoscopy of the nose or throat and cautery and/or packing for nasal bleeding.

* They are billed in addition to the office evaluation. If you prefer not to have any of these procedures done, please let us know in advance

* Non-emergency treatment may be denied if:
  - A minor under eighteen is unaccompanied by an adult
  - A patient does not have a valid insurance card
  - A referral is unobtainable (when required by the insurance)
  - A patient has been delinquent on balance and/or the account has been sent to our "collection agency"
  - A patient has missed more than three previous appointments and has been advised of being denied another appointment

* We accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.

* Failure to show for an appointment will result in a $35.00 administration fee.

* Cancellations within 24 hours of appointment will result in a $35.00 administration fee.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns. I, _____have read and understand the conditions for payment to Colden & Seymour Ear Nose Throat & Allergy as outlined above.

Signature_____ DATE _____

(patient signature or signature of parent/guardian if pt is a minor under 18)

Notice of Health Information Privacy Practices

Our use of your health and demographic information

1. Basis for planning your medical treatment
2. Means of communication among health professions involved in your treatment
3. Legal document describing your treatment
4. Basis for obtaining payment including third party payer verification of services billed
5. Basis for regular health operations including risk or quality improvement
6. Tool in educating health professionals
7. Source of information for public health officials, law enforcement, correction institutions, workers compensation as required by law

Your health information rights

1. Obtain a copy of this notice of information practices upon request
2. Obtain a copy of your health information as provided for in (45CFR 164.524).
3. Amend your health information (45 CFR 164.528)
4. Obtain an accounting of disclosures of your health information (45 CFR 164.528)
5. Request disclosure of your health information by alternative means or at alternative locations
6. Request restriction on uses and disclosure of your health information (45 CFR 164.522)
7. Revoke your authorization to use or disclose your health information except to the extent that action has already been taken
8. Receive a copy of any revisions to this notice

Our responsibilities and rights

1. Maintain the privacy of your health information
2. Provide you with this notice
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction
5. Accommodate reasonable requests regarding disclosure of health information by alternative means or at alternative locations
6. Discontinue use or disclosure of your health information with receipt of your written revocation of authorization
7. Reserve the right to revise this notice (CFR164.520)
8. Provide a copy of any revisions to this notice to the address provided by you

For more information or to report a problem

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or
With the Office for Civil Rights without retaliation:
Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Bldg
Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices from the office of Colden & Seymour Ear Nose Throat & Allergy.

Name of Patient (Please print) _____

Signature of Patient _____
(patient signature or signature of parent/guardian if pt is a minor under 18)

Date: _____