Otolaryngology Specialty Care, LLC
Christopher E Stevens, M.D.
2345 NorthPark Dr. Columbus, IN 47203
(812) 669-1490
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We would like to welcome you to Otolaryngology Specialty Care, LLC, the office of Christopher E. Stevens, M.D. This is to confirm that you are scheduled for an appointment at our office.

***Please complete the enclosed medical forms and Fax, E-mail, or mail back to our office so that we receive them a week prior to your appointment. If you are mailing them please ensure that you allow enough time for transit. If the completed forms are not received at least two business days prior to your appointment please be aware that this will cause a delay in being seen by the doctor, adding unnecessary wait time to your scheduled appointment.**

Please be sure to bring all insurance cards as well as a picture ID. Any co-payments will be collected at the time of service.

Please contact our office if you have any questions prior to your appointment.

Thank you.

Satellite offices:

Decatur County Memorial Hospital
720 N. Lincoln
Greensburg, IN 47240

Margaret Mary Outpatient & Cancer Center
24 Six Pine Ranch Rd
Batesville, IN 47006

Otolaryngology Specialty Care, LLC

We would like to take this opportunity to welcome you to our practice, and thank you for choosing Otolaryngology Specialty Care. The following are office policies that should be reviewed prior to your appointment.

- **To provide excellent quality care, we request new patients please bring any recent CT or MRI images with you (on a CD)** which you may feel are important to your visit. You can get these from the radiology department where you had the scans done. Also, please bring a current medication list whether they are prescribed or over the counter.

- **If this appointment is for a minor, a parent/legal guardian will need to accompany them** and be present for every visit. The parent or legal guardian may give written consent for another adult to bring the child to *future* appointments; however the parent/legal guardian MUST be present at the initial visit with their photo ID.

- **Please confirm that we are providers for your insurance plan.** Our staff will do their best to let you know if our physician is considered out-of-network for your plan. However, it is your responsibility to know your insurance plan.

- **Please bring your current insurance card to your appointment along with a picture ID.** If you do not bring your insurance card our staff cannot verify insurance coverage at the time of your appointment & the visit will be considered self-pay with full payment expected at the time of service.

- **If you must cancel your appointment please give our office 24 hours notice or as much time as possible** so that we may schedule someone else as we have a waitlist of patients needing to be seen.

- **At the time of your office visit or at a follow up visit our physician may require additional tests** and/or diagnostic procedures in order to care for you. Depending on your insurance coverage, these procedures may require an additional co-payment/deductible or insurance authorizations.

AUDIO NEEDS TO BE SCHEDULE WHEN YOU SUFFER FROM:

SUDDEN HEARING LOSS OR CHANGE

ACUSTIC NEUROMA

BELLS PALSY OR FACIAL NUMBNESS/DROOPING

BUZZING/TINNITUS/RINGING IN THE EARS

CHOLESTEAOMA

EUSTACHIAN TUBE DYSFUNCTION

HEARING LOSS

MENIER'S DISEASE/ DIZZINESS/VERTIGO/IMBALANCE

EAR PAIN/ EAR PRESSURE

EAR INFECTIONS/ FLUID IN EAR

OTOSCLEROSIS

EARDRUM PERFORATION

SPEECH DELAY

PLEASE CALL TO SCHEDULE AND HAVE YOUR AUDIO DONE <u>PRIOR</u> TO YOUR APPOINTMENT

COLUMBUS	**GREENSBURG**	**BATESVILLE**
(812) 669-1490	(812) 663-1252	(812) 933-5110

Please **PRINT** legibly. If something does not apply, please mark N/A. **DO NOT LEAVE ANYTHING BLANK.**

Today's date:_____ Appointment date: _____

PATIENT INFORMATION

First name:	Middle Initial:	Last name:	Birth date: / /	Age:
Mailing address:		City:	State:	Zip Code:
Primary phone #: ❑Home ❑Cell ❑Work ( ) *Contact name:		Secondary phone #: ❑Home ❑Cell ❑Work ( ) *Contact name:	Other phone #: ❑Home ❑Cell ❑Work ( ) *Contact name:	
Sex: ❑ M ❑ F	Race/Ethnicity: ❑Caucasian ❑African American ❑American Indian ❑Alaska Native ❑Native Hawaiian ❑Asian ❑Hispanic ❑**Not** Hispanic			

MOTHER OR GUARDIAN INFORMATION

First name:	Middle Initial:	Last name:	Birth date: / /	Employer:
Address: ❑Same as patient ❑Other (please specify):		City:	State:	Zipcode:
Primary phone #: ❑Home ❑Cell ❑Work ( )		Secondary phone #: ❑Home ❑Cell ❑Work ( )	Email:	

FATHER OR GUARDIAN INFORMATION

First name:	Middle Initial:	Last name:	Birth date: / /	Employer:
Address: ❑Same as patient ❑Other (please specify):		City:	State:	Zipcode:
Primary phone #: ❑Home ❑Cell ❑Work ( )		Secondary phone #: ❑Home ❑Cell ❑Work ( )	Email:	

INSURANCE INFORMATION

Insurance company for billing claims:	ID #:	Group #:	Plan code (Anthem only):
Insurance Address (back of card; excluding Anthem):	City:	State:	Zip Code:
Name of person who carries insurance:	Relationship to patient:	Insured birth date: / /	Insured employer:

SECONDARY INSURANCE INFORMATION

Insurance company for billing claims:	ID #:	Group #:	Plan code (Anthem only):
Insurance Address (back of card; excluding Anthem):	City:	State:	Zip Code:
Name of person who carries insurance:	Relationship to patient:	Insured birth date: / /	Insured employer:

Please **PRINT** legibly. If something does not apply, please mark N/A or None. **DO NOT LEAVE ANYTHING BLANK**.

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ City & Street: _____

Recent: (circle) Labs/X-Rays/CTs/MRIs/Ultra Sounds: ☐No ☐Yes- Location: _____

Reason for visit- **SYMPTOMS** you are experiencing:_____

_____

For this medical issue, how many episodes have you had in the past 12 months, **even if you were not seen by a doctor**?

_____episodes - On average, how long do these episodes typically last? _____ days/weeks/months (circle one)

Past Surgical History	Date (If known)	Hospitalized Overnight?	Overnight Hospitalizations (excluding surgeries)	Date (If known)
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No	☐ None (Check if none in **lifetime**)	
		☐ Yes ☐ No	**Current/Chronic Medical Problems**	
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
☐ None (Check if none in **lifetime**)			☐ None (Check if none)	

Family History

Y N
- ☐ ☐ Cancer:_____
- ☐ ☐ Alzheimer's Dz
- ☐ ☐ Dementia
- ☐ ☐ Heart Dz
- ☐ ☐ Thyroid Dz
- ☐ ☐ High Blood Pressure
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Diabetes
- ☐ ☐ High Cholesterol
- ☐ ☐ Glaucoma
- ☐ ☐ Kidney Dz
- ☐ ☐ Liver Dz
- ☐ ☐ Parkinson's Dz
- ☐ ☐ Leukemia
- ☐ ☐ Hearing loss

☐ Other:

Please check the appropriate box for symptoms or illnesses. Every symptom or illness **MUST** be checked with yes or no. Some symptoms/illnesses are referring to the child's current wellbeing & some are referring to the child's medical history. Please read carefully.

Y N
- ☐ ☐ History of Jaundice
- ☐ ☐ High blood pressure
- ☐ ☐ Diabetes- Type:_____
- ☐ ☐ Asthma/Hayfever
- ☐ ☐ Heart trouble/Murmur
- ☐ ☐ History of Pneumonia- Date:_____
- ☐ ☐ Nervous/Psychiatric disorder
- ☐ ☐ Lung problems
- ☐ ☐ Shortness of breath
- ☐ ☐ Weakness/Tiredness
- ☐ ☐ History of Measles
- ☐ ☐ History of Mumps
- ☐ ☐ History of Chicken pox
- ☐ ☐ History of Blood transfusion

If yes, date:_____

Y N
- ☐ ☐ Hyper activity/ADD/ADHD
- ☐ ☐ History of Diphtheria
- ☐ ☐ History of Scarlet fever
- ☐ ☐ History of Rheumatic fever
- ☐ ☐ History of Polio
- ☐ ☐ History of Meningitis
- ☐ ☐ History of Encephalitis
- ☐ ☐ Arthritis/Joint pain
- ☐ ☐ History of Tuberculosis
- ☐ ☐ Bleeding disorder (child or family)
- ☐ ☐ **Immunizations up to date?**
- ☐ ☐ **Child in daycare?**

***Child's weight:**_____ lbs.

***Child's height:**_____ft. _____in.

Food and Drug Allergies: ☐No ☐Yes(please list):____

____

MEDICATIONS

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING WITH THE **DOSAGE** AND **FREQUENCY**:

MEDICATION NAME	DOSAGE (ie. mg, mcg)	FREQUENCY (ie. X2 per day)	REASON FOR TAKING
☐ None (check if take NO medications at all)			