

Otolaryngology  
Pediatric Otolaryngology  
Allergy  
Facial Rejuvenation  
Audiology  
Hearing Testing  
Hearing Aid Dispensing

**Peter F. Agnello, M.D.**  
Otolaryngology  
Head & Neck Surgery  
Board Certified  
American Board of Otolaryngology

**Yoon C. Nofsinger, M.D.**  
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**Sierra MacDonald, Au.D., CCC-A**  
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**Rachel Horne, Au.D., CCC-A**  
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Locations  
Tampa and Wesley Chapel

Dear Patient:

Welcome to Tampa Ear Nose & Throat Associates. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you find this information useful.

Our office hours are Monday through Friday from 9:00AM to 5:00PM. Our office phone number is 813-972-3353. In the event of an emergency outside of our normal business hours patients may call this number and the call service will contact the doctor on call for you.

We understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that you call our office at least 24 hours prior to your appointment time. If you fail to contact our office in advance three times over the course of one year you will be discharged from the practice.

Patients should complete, sign and bring the following to your first appointment:

- Patient registration form
- Conditions of treatment form
- Health questionnaire
- Medication list
- Allergy patient information (if applicable)
- Allergy questionnaire (if applicable)
- Drivers license or state issued identification card
- Primary and secondary insurance cards

On subsequent visits our front office staff will review your demographic and insurance information with you to ensure we maintain your correct information on file. This allows us to submit your claim to your insurance carrier in a timely manner.

We are contracted with several insurance carriers for the benefit of our patients. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physicians are listed as providers within your network. As part of our contract with the insurance companies we are legally required to collect any co-pays or deductibles from you at the time of service. We ask that you be prepared to pay your co-pay at the time of check out. We accept cash, check, American Express, Discover, MasterCard, and Visa.

**If your insurance requires a referral from your primary care physician, a written referral or authorization number must be in our office 48 hours prior to your visit or your appointment will be cancelled. Obtaining this authorization is the responsibility of the patient. Please contact your primary care physician as soon as possible to initiate this process.**

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It is our desire to have a mutually respectful relationship with our patients. As part of the relationship we feel it is important to set patient expectations appropriately:

- Patient telephone messages must first be reviewed by clinical staff prior to a return telephone call. In most cases, this process may take 4-6 hours. Please note, for messages left after 12PM, you may not receive a return phone call until the following business day.
- Please allow 2 working days for the clinic to process requests for prescription refills and 3 working days to process authorizations for diagnostic testing.
- Please allow 5-7 working days for the completion of any forms, letters, or records requests. There is a standard fee for any form completion including FMLA. This amount is per form and based on the number of pages per form. This amount is due at the time the forms are submitted to our office.
- Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.
- We expect our patients to maintain a good credit rating with our office. Failure to pay for medical services delivered in good faith will cause your account to be turned over to a third party collection agency and you will be discharged from the practice.

If you have any questions or need further clarification on any of our policies please contact our office for assistance. Thank you for allowing us to assist you with your healthcare needs.

Sincerely,

Tampa Ear Nose & Throat Associates

**Tampa Ear Nose & Throat Associates Patient Registration** *(please print clearly)*

**Patient Information**

Date: \_\_\_\_\_ Patient SSN: \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status *(please circle)*: Single Married Divorced Widowed Legally Separated  
Primary Care Physician: \_\_\_\_\_ Pharmacy Name/Phone: \_\_\_\_\_

**Responsible Party**

**Permanent Address**

Name: \_\_\_\_\_ Street: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ **Billing Address (If Different)**  
Cell Phone: \_\_\_\_\_ Street: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Subscriber / Policy Holder Information**

Primary Carrier: \_\_\_\_\_ Secondary Carrier: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
Subscriber DOB: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
Subscriber SSN: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_  
Group ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

**Employment Status Patient / Parent or Guardian**

*Please circle:*      Employed      Self Employed      Retired      Disabled      Unemployed      Student  
Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONDITIONS OF TREATMENT BY  
TAMPA EAR NOSE & THROAT ASSOCIATES**

**Patient** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Permission for Treatment:** Permission is hereby granted for physicians, residents, employees or agents of Tampa Ear Nose & Throat Associates (collectively, the "Provider") to render the patient named above such medical and surgical treatment as is deemed necessary.

**Authorization for Release of Information:** The Provider (through its employees or other contracted agents) may disclose the patient's medical record account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges; including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

**Financial Agreement:** (Please initial as applicable)

\_\_\_\_\_ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to Tampa Ear Nose & Throat Associates all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

\_\_\_\_\_ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

\_\_\_\_\_ **Self-Paying Patient:** I have been informed that Tampa Ear Nose & Throat Associates does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician/PCP: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for visiting today (location, quality, severity, duration, timing, context, associated symptoms): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all major medical problems (diabetes, high blood pressure, stroke, heart attack, asthma, cancer): \_\_\_\_\_  
\_\_\_\_\_

List all surgeries or hospitalizations (include date, medical illness, and complications): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or have you ever used tobacco? (type, duration, amount per day): \_\_\_\_\_  
\_\_\_\_\_

Do you drink alcohol? (type, duration, amount per day): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family history (hearing loss, ear problems, cancer, anesthesia complications, bleeding history, diabetes, allergies): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current occupation, marriage status, children, siblings, hobbies, pets: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications you take each day (include aspirin, motrin, herbal remedies): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medications? List medication and allergic reaction: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any seasonal allergies (pollen, grass, weeds, trees), environmental allergies (dust mites, mold, animals, latex) or food allergies (avocado, apples, melon)? If yes, please complete the additional allergy questionnaire.

Physician signature \_\_\_\_\_

Date \_\_\_\_\_

Do you have problems with any of the following?

Please circle NONE, circle all that apply or add additional information

General: NONE, weight loss, weight gain, night sweats, fever, fatigue, other \_\_\_\_\_

Skin: NONE, mole, rash, hives, keloid, eczema, other \_\_\_\_\_

Eyes: NONE, blurry vision, glaucoma/cataract, pain, tearing, other \_\_\_\_\_

Ears: NONE, hearing loss, imbalance, vertigo, drainage, pain, tinnitus, ear pressure, history of frequent ear infections (\_\_\_\_# per year), other \_\_\_\_\_

Nose: NONE, congestion, nasal blockage, facial pain/pressure, post nasal drip, inability to smell, frequent sinus infections (\_\_\_\_# per year), clear nasal discharge, discolored nasal discharge, sneezing, other \_\_\_\_\_

Throat: NONE, pain, difficulty swallowing, difficulty breathing, hoarseness, cough, frequent throat clearing, frequent tonsillitis (\_\_\_\_# per year), foreign body, snoring (with or without apnea), feel something stuck in throat, other \_\_\_\_\_

Dental: NONE, TMJ pain, teeth grinding, teeth clenching, recent dental work (date \_\_\_\_\_) other \_\_\_\_\_

Pulmonary: NONE, wheezing, shortness of breath, noisy breathing/stridor, COPD, emphysema, supplemental oxygen, other \_\_\_\_\_

Cardiovascular: NONE, chest pain, heart murmur, mitral valve prolapse, other \_\_\_\_\_

Gastrointestinal: NONE, heartburn, constipation, bad taste in mouth, ulcer, other \_\_\_\_\_

Genitourinary: NONE, kidney stones, urinary tract infections, other \_\_\_\_\_

Gynecology: NONE, pregnancy, breast feeding, postmenopausal, yeast infections, other \_\_\_\_\_

Musculoskeletal: NONE, arthritis, fibromyalgia, weakness, artificial joints, other \_\_\_\_\_

Neurologic: NONE, memory loss, depression, anxiety, Alzheimer's, schizophrenia, head trauma, ADD/ADHD, other \_\_\_\_\_

Hematologic: NONE, easy bruising, gum bleeding, anemia, history of blood transfusions, Jehovah's witness (refuse blood transfusions), other \_\_\_\_\_

Infectious: NONE, autoimmune deficiency, mumps, measles, mononucleosis, HIV, HIV risk factors, hepatitis C, hepatitis B, other \_\_\_\_\_

Physician signature \_\_\_\_\_

Date \_\_\_\_\_



## ALLERGY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

1. Rank your top MOST BOTHERSOME allergy symptoms:

a.	c.	e.
b.	d.	f.

2. List any family members who have allergies or who are receiving treatment: \_\_\_\_\_

3. Have you had allergy testing in the past? (Yes / No)

If yes, how were you tested (circle one) a. Blood Test or b. Skin Testing

4. Are you currently or have you ever received allergy shots? (Yes / No)

Please list start date and end date of shots: \_\_\_\_\_

Did you feel better when you were receiving allergy shots? (Yes / No)

Why did you discontinue allergy shots? \_\_\_\_\_

5. Have you ever experienced a life threatening reaction to insect bites, foods or medications? (Yes / No)

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

6. Do you have ASTHMA or have you ever had Asthma? (Yes / No)

7. Did you have colic as an infant or experience any problems with formula/breast milk? (Yes / No)

8. Do you wake up in the middle of the night between 1-5 AM? (Yes / No)

9. Do you experience spaciness and poor memory at times? (Yes / No)

If so, are these episodes related to allergy flare ups? (Yes / No)

10. Do you have hyperactivity or mood swings? Describe a typical event: \_\_\_\_\_

\_\_\_\_\_

11. What type of home do you have? (Apartment / House / Trailer)

Do you have carpeting in your bedroom? (Yes / No)

How old is your home: (< 5 years old, 6-10 years old, > 11 years old)

Is your home dusty? (Yes / No)

Have there been any recent home renovations? (Yes / No)

Have you ever had a mold problem? Flooding/leaking roof? (Yes / No)

Do you have Asian Beetles (resemble ladybugs) in your home? (Yes / No)

12. List all indoor pets: \_\_\_\_\_

Do your allergy symptoms worsen when coming into contact with any animals?

Describe the reaction: \_\_\_\_\_

13. Do you have problems with yeast infections? Circle all that apply

Vaginal yeast infections  
Fungal in toe nails

Candida in skin folds in groin, stomach, under breasts  
Oral thrush or Candida

14. Do you have skin rashes or eczema? Describe location and frequency \_\_\_\_\_

\_\_\_\_\_

15. How often have you been on antibiotics in the past year? \_\_\_\_\_

List the antibiotics: \_\_\_\_\_

16. Which of the following situations or items make your symptoms worse?

Indoors	Heater on	Milk	Tobacco
Outdoors	Mowing lawn	Eggs	Newspaper
At home	Yard work	Soy	New fabric
At work	Dusting / vacuuming	Wheat	Cat
At school	Damp places	Yeast	Dog
Morning	Air conditioning	Corn	Stores
Dry weather	Afternoon	Peanut	Perfume
After rain	Fronts	Seafood	Chlorine
Other: _____			

17. During which months do you feel worse?

January	April	July	October	All months
February	May	August	November	No pattern
March	June	September	December	

18. Do you avoid some foods? Describe the symptoms you experience with these foods? \_\_\_\_\_

\_\_\_\_\_

19. Do you crave any foods? \_\_\_\_\_

20. Circle all symptoms you typically experience after eating:

Cramping	Headache	Burping	Blurry vision
Diarrhea	Nasal blockage	Coughing	Throat itching
Throat clearing	Runny nose	Gas	Oral itching
Fatigue after meals	Nausea	Bloating	

21. What foods do you eat at least 3 times per week? Circle all that apply.

Coffee	Chocolate	Ice cream	Orange Juice	Peanut	Beef
Tea	Rice	Candy	Corn	Coke / Pepsi	Beer
Bread	Milk	Yogurt	Soy	Diet drinks	Wine
Cookies	Cheese	Fish	Apples	Pork	Egg

22. Rate your quality of life with regard to your allergy symptoms:

1	2	3	4	5	6	7

1 = Quality of life is terribly affected in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

2 = Quality of life is affected almost all the time in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

3 = Quality of life is affected often in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

4 = Quality of life is affected occasionally but is tolerable in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

5 = Quality of life is hardly affected in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

6 = Quality of life is so mildly affected it is hardly noticed in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

7 = Excellent quality of life in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social and/or recreational activities

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**Please be advised that we are a specialty care practice and some services performed in the office may be charged in addition to an office visit.**

**These charges are separate from your co-payment and may apply to your co-insurance and/or deductible depending on your insurance plan.**

**These services include but are not limited to:**

- Any type of scope
- Control of nose bleeds
- Removal of foreign bodies
- Wax removal
- Sinus debridement
- Biopsies
- Excisions
- Audio services
- Somnoplasty
- Tympanostomy
- Videostrobe

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_