Diplomate American Board of
Facial, Plastic & Reconstructive Surgery

Eric M. Joseph, M.D.

Diplomate American Board of
Otolaryngology

Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes **E-mail** _____

Contact Restrictions: _____ How often do you check your e-mail ❒ Daily ❒ Weekly ❒ Rarely

Age _____ Birthdate _____ **SS#** _____ **Sex** ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Your Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Preferably, not in the household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ **DOB** _____ **Relationship To Patient** _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ **Relationship to patient** _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

From what source did you learn about our office?

☐ Primary care physician(name,address) _____

☐ Friend or family member(name) _____

☐ Local Newspaper, magazine (name) _____

☐ Other _____

What is the main ***REASON(S)*** you are here to see Dr.Joseph?_____

_____

Do you have ***ALLERGIES*** to any medications? Yes ☐ No ☐ If yes, Please list all the medications and the allergic reaction:_____

_____

Do you take ***MEDICATIONS?*** Yes ☐ No ☐ If yes, Please list all the medications you take including the dosage and frequency:

_____

_____

Please check any of the following medical problems which you have had.

☐Diabetes	☐Glaucoma	☐Tuberculosis
☐Sickle cell anemia	☐Epilepsy	☐Hepatitis
☐Syphilis	☐AIDS	☐HIV+
☐Emphysema	☐Asthma	☐Lung Disease
☐Kidney Disease	☐Liver Disease	☐Stroke
☐High Blood Pressure	☐Heart Attack	☐Heart Disease
☐Stomach ulcer	☐Duodenal ulcer	☐Bleeding Problems
☐Scarring Problems	☐Problems with Anesthesia	☐Birth Defect(s)
☐Migraine Headaches	☐Mental illness	☐Suicide attempt(s)

☐Cancer, if yes what type?_____

☐Other:_____

Have you had any ***SURGERIES?*** Yes ☐ No ☐ If yes, Please list all the the surgeries that you had, including the year of surgery:

_____

Have you ever had **dental/wisdom teeth** extracted?	☐yes	☐no	
Have you taken Aspirin in the last two weeks?	☐yes	☐no	
Have you ever smoked?	☐yes	☐no	if yes, how many cigarettes daily?_____
Do/have you drink alcohol regularly?	☐yes	☐no	
Do/have you ever use (d) intravenous drugs?	☐yes	☐no	
Have you ever used cocaine?	☐yes	☐no	if yes, most recent usage_____
Have you ever taken Accutane for acne	☐yes	☐no	if yes, when? _____

Review of Systems: please check any of the following medical problems that you or your family member has ever experienced.

General	**self**	**family**
tire easily, weakness	☐	☐
marked weight change	☐	☐
night sweats	☐	☐
Persistent fever	☐	☐
Emotional problem	☐	☐
Chills	☐	☐
Skin		
Eruption (rash, hives)	☐	☐
Change in skin color	☐	☐
Eyes		
Visual change	☐	☐
Glaucoma	☐	☐
Frequent itching	☐	☐
Excessive tearing	☐	☐
Wear contacts/glasses	☐	☐
Pain	☐	☐
Dry eyes	☐	☐
Ear		
Loss of hearing	☐	☐
Ringing in the ears	☐	☐
Pain	☐	☐
Drainage	☐	☐

Mouth and Throat	**self**	**family**
sore	☐	☐
hoarseness	☐	☐
heartburn	☐	☐
cough	☐	☐
dentures	☐	☐
snoring	☐	☐
Difficulty breathing	☐	☐
difficulty swallowing	☐	☐
difficulty speaking	☐	☐
difficulty sleeping	☐	☐
Head, Face and Neck		
skin growth	☐	☐
lump/swelling	☐	☐
pain	☐	☐
numbness	☐	☐
headaches	☐	☐
Nose and Sinuses		
Frequent nosebleeds	☐	☐
Sinus problems`	☐	☐
Breathing problems	☐	☐
Nasal allergy	☐	☐
Sneezing	☐	☐
Loss of sense or smell	☐	☐

Ear		
Swelling	☐	☐
Fullness	☐	☐
Wear hearing aids	☐	☐
Itching	☐	☐

Nervous System	**self**	**family**
Stroke	☐	☐
Convulsion/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐

Endocrine		
Diabetes	☐	☐
Thyroid condition	☐	☐

Heart/Blood Vessels		
Chest pain/discomfort	☐	☐
High blood pressure	☐	☐
Pneumatic fever	☐	☐
Heart murmur	☐	☐
Sickle cell anemia	☐	☐
Heart attack/trouble	☐	☐
Swelling of ankles	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐

Bones/muscles		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐

Respiratory		
Shortness of breath	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Persistent cough	☐	☐
Sputum Production	☐	☐
Lung Disease	☐	☐

Blood	**self**	**family**
Bleed/bruise easily	☐	☐
anemia	☐	☐
blood transfusion	☐	☐

Digestive System		
heartburn/reflux	☐	☐
hepatitis/liver disease	☐	☐
Ulcer disease	☐	☐
jaundice	☐	☐
change in appetite	☐	☐
black, bloody/pale stool	☐	☐

Urinary		
increase in frequency of -		
urination	☐	☐
burning on urination	☐	☐
urethral discharge	☐	☐
bloody urine	☐	☐
venereal disease	☐	☐
kidney disease	☐	☐

Other		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
Syphilis	☐	☐
AIDS	☐	☐
Lyme disease	☐	☐
Suicide attempt(s)	☐	☐
Birth defects (s)	☐	☐

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Joseph to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Joseph and myself.

Signature of PATIENT or legal guardian_____ Date_____

This is to verify that I have received a copy of Dr. Joseph's **patient confidentiality statement.**

Signature of PATIENT or legal guardian X_____Date_____

When confirming future appointments would you like to be
e-mailed ☐ called ☐

MUTUAL AGREEMENT

"I", "Patient/Guardian" shall be understood to mean .
"Physician" shall be understood to mean **Dr. Eric Joseph.**

Dr. Eric M. Joseph and Joseph Otolaryngology, P.C. (collectively labeled *"Physician")* agree to provide treatment to: **(***"Patient"*). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are almost always forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Even after recent Congressional attempts to tighten this restriction, however, there are still exceptions for drugs currently prescribed to the patient and for recommending items or services covered by the patient's health plan. More importantly, there is no prohibition against a physician putting his patient on the spot and asking for permission to allow third parties access to information to market to patients, which could authorize essentially unlimited unwanted marketing information. Even to the extent still allowed, Physician agrees not to allow others access to use Patient's medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's permission for a third party to market directly to Patient.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician – his practice, expertise, and/or treatment – on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Importantly, Physician agrees to abide by a Code of Internet Ethics. What that means: Physician agrees to enforce no rights enabled by the assignment if Patient's commentary conforms to typical Internet Rating Sites' Terms of Use (such as Google Maps-see http://www.google.com/help/terms_maps_earth.html). Such terms include, as examples, no obscenity, no personal attacks, and the like. To be clear, constructive commentary, even if negative, helps us build a better practice. The Code of Internet Ethics encourages posting of all constructive commentary, good, neutral, and even negative.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this Agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS:_____DAY OF _____. X _____

Signature of PATIENT/Guardian

ERIC M. JOSEPH, MD

Joseph Otolaryngology, P.C.

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean .
"Physician" shall be understood to mean **Dr. Eric Joseph.**

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I(the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Academy of Facial Plastic and Reconstructive Surgery and American Academy of Otolaryngology - Head and Neck Surgery.

In further consideration for this Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____ X _____

Physician Patient/Guardian

_____ _____

Effective from Date of Treatment: Date of Signature