Island ENT Wellness and Audiology
Medical and Surgical Expertise with a Holist Approach
420 Nokomis Avenue S, Venice FL 34285 call 941-786-0386 fax 941-761-6241
www.IslandENTVenice.com

Name: _____ Birthdate ____/____/____
FL Address_____
Email _____ Permission to text?_____
Landline _____ Cell _____
Snowbird? Second address_____

Reason for your visit today _____

Treatment tried _____
Did you have any scans? Did you bring them? Where performed? _____

Primary Doctor _____ Pharmacy (**location**?)_____

Who can see your medical records? (relation)_____

HT_____ Weight _____ T_____ P_____ BP _____ O2_____%

Allergies to drugs, food or environment reaction? Mild, mod, or severe. Type of reaction

Permission to use a national database of pharmacies to access medication list? **Y / N**

Medication, supplements, herbals dose (mg), how often taken,

Social history: (Circle). Never smoker, Ex Smoker. Smoker ___ cigs. per day
Alcohol: do not drink, former drinker, 0-4 glasses/month, 1-2/wk 1-2/day, 3 or more/day

Significant **family history** or trauma that relates to your health?

Your Medical history: Please list any significant information Circle any that pertain:
Cardiologist _____Heart Disease, Afib, CAD, Stents,High Blood Pressure, Bleeding Disorders or thinners, CHF,
Pulmonologist _____COPD, Short of breath, Asthma, pulmonary hypertension, PE,
Neurologist _____ seizures, black outs, neuralgia, Headaches,
Gastroenterologist _____ Reflux or heartburn, gastric emptying issues, chronic constipation, Chrones, food intolerances
Other stuff: Hepatitis, Thyroid issues, Kidney Disease, TB, HIV/AIDS, Diabetes, Stroke, recent change in weight, Joint Pain, problems with anesthesia Y or N Cancer (list details below), list any others

_____

_____

_____

_____

Sinus Problems: Pain and pressure in cheeks or forehead? Have you had a CT scan of your head? Have you used Flonase? Y or N Do you use a saline sinus rinse Y or N Other nasal sprays? Sinus Surgeries? Antibiotics in the last year for sinus infections?

Sleep Problems: use C-Pap? Do you tolerate it well? Y or N, why not _____
Last sleep study within 2 years? _____ Known sleep apnea? Y or N Do you disturb your partner?

Hearing/Ear Problems: Do you have hearing loss? Y or N Tinnitus? Y or N Ear pain? Which side?
Trouble equalizing pressure in ears? Wax buildup? Last hearing test? Where?
Hearing Aids? Brand?
Do you wish they worked better?

Surgical History: please list anything done, approx. date, surgeon if known , knowing you had anesthesia helps us prepare for future needs

We ask all patients to bring any outside test or scans with them so we can get a better idea of your health.

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RELEASE OF MEDICAL RECORDS

I, (name) _____ request the following doctor's offices send my records to Island ENT, also that Island ENT send my records to them as needed.

DOB: ____ / ____ / _____ phone number: _____

List physicians and healthcare team you would like us to send and receive records

Name of physician or practice below	specialty	phone number	fax number
1.			
2			
3			
4			
5			
6			

To: Medical Records	From: Island ENT 941-761-6241 Dr. Michael Jonathan Clark MD Dr. Madeleine Berg Au.D
Date sent	Date received

Please sign _____date_____

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Consent to Treat and HIPAA Notice

Patient Name: _____

At Island ENT , it may be required for me to undergo physical examination or other diagnostic procedures and treatment that is deemed necessary by the treating doctor. The nature/need for the procedure will be explained prior and I am able to refuse any treatment or procedures. I consent to procedures deemed necessary, diagnostic study, disposal of bodily fluids/ tissue obtained with routine hospital/governmental regulation, prescription and/or administration of medication. All explanations of treatments/procedures/ medication administration will include intended purpose, reasonable foreseeable risks, consequences, benefits, and alternatives which may be used or performed in the course of diagnosing/treating. I understand that treatments/procedures/medication administration will not be exhaustive and that other risks or complications may arise, but the likelihood is not reasonable or foreseeable. I have been advised that if I would like a more detailed explanation prior to consent, that one will be given to me. I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result from examination(s), procedure(s), or treatment(s), which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I consent to photographing and/or videotaping the appropriate portions of my body, which are pertinent to showing my physical condition for medical, scientific, or education purposes provided reasonable precautions are taken to conceal my identity. I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make inquiries regarding any aspect of my diagnosis or treatment which I do not understand. By signing below, I represent to my doctor and this practice that I am eligible to give this consent.

Island ENT follows HIPAA guidelines in respect to Protected Health Information (PHI). Your PHI may be used or disclosed for the purpose of treatment, payment, or health care operations. Please see our Notice of Privacy Practices for an extensive overview of practices and patient's rights. Signing below also indicates that I received a notice of privacy practices and agree to allow this practice to use my health information as indicated above.

_____ _____

Patient or Representative Signature* Date
Parent if under 18 years of age

_____ _____

Relationship to Patient Signature of Witness

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WHAT IS TINNITUS?

Please use this form if you are experiencing Tinnitus

Tinnitus, pronounced as tin-NIGH-tis or TIN-uh-tis, is the perception of sounds or noises in one ear, both ears, or the head. These sounds can be perceived as ringing, buzzing, roaring, hissing, crickets, static, dial tone, pulsing, or whooshing.

It is estimated that over 25 million Americans per year experience tinnitus. Many of these individuals experience chronic tinnitus, meaning the perception does not dissipate. Tinnitus can be an indication of damage to the ear, leading to a disruption of how sound is relayed to the brain.

COMMON CAUSES OF TINNITUS

- Noise induced hearing loss / Acoustic trauma
- Age related hearing loss
- Earwax occlusion the ear canal
- Ototoxic Medication
- Head Injury / TBI
- Temporomandibular Joint Disorder / TMJ
- Sinus Pressure/ Barometric Trauma
- Stress
- Migraine
- Lack of Sleep

- Other Medical Conditions (not limited to):
  - Hypo/Hyper-thyroidism, Anemia
  - Lyme Disease, Fibromyalgia
  - High Blood Pressure, Atherosclerosis
  - Depression, Anxiety, Stress
  - Meniere's Disease, Thoracic Outlet Syndrome, Otosclerosis
  - Tumor Related (rare): Acoustic Neuroma, Vestibular Schwannoma, or other tumorous growths

Managing Tinnitus

Sound Therapy
- Hearing aids, sound generators
- Soundhttps://www.ata.org/about-tinnitus/sound-therapy/

Stress Management
- Physical/ Social Activity
- Recreation activities/ hobbies

Counseling / Cognitive Behavior Therapy / Acceptance and Commitment Therapy/ Biofeedback Hypnosis, Lenire (coming soon to Island ENT), www.lenire.com/what-is-lenire/eatment Device (lenire.com)

Change in Diet/ Lifestyle
- Healthy Diet and exercise
- Reduction of caffeine, preservative, alcohol, smoking
- https://www.ata.org/about-tinnitus/tinnitus-health-newsletter/tinnitus-health-newsletter-issue-7/the-role-of-diet-in-tinnitus-and-hearing-health/

Support Groups
www.ata.org/your-support-network/find-a-support-group/

Medication Recommended by Physician/ENT
- Lipoflavinoids
- Treatment of underlying conditions

If you are experiencing tinnitus, please fill out the questionnaire on the back and return to a staff member.

American Tinnitus Association. (2019). *What you should know about tinnitus - ata.org.* Retrieved October 4, 2022, from https://www.ata.org/wp-content/uploads/2022/08/ATA-Tinnitus-and-Membership-Flyer-2019.pdf

American Speech-Language-Hearing Association. (n.d.). *Tinnitus.* Retrieved October 5, 2022, from https://www.asha.org/public/hearing/tinnitus/

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Your name: _____ **Date:** _____

Instructions: The purpose of this questionnaire is to identify, quantify, and evaluate the difficulties that you may be experiencing because of tinnitus. Please do not skip any questions. When you have answered all the questions, add up your total score, based on the values for each response.

1.	Because of your tinnitus, do you have difficulty concentrating?	**Yes** (4)	**Sometimes** (2)	**No** (0)
2.	The volume (intensity) of your tinnitus makes it difficult for you to hear people?	**Yes** (4)	**Sometimes** (2)	**No** (0)
3.	Does your tinnitus make you angry?	**Yes** (4)	**Sometimes** (2)	**No** (0)
4.	Does your tinnitus make you feel confused?	**Yes** (4)	**Sometimes** (2)	**No** (0)
5.	Because of your tinnitus, do you feel hopeless?	**Yes** (4)	**Sometimes** (2)	**No** (0)
6.	Do you complain a great deal about your tinnitus?	**Yes** (4)	**Sometimes** (2)	**No** (0)
7.	Because of your tinnitus, do you have trouble falling asleep at night?	**Yes** (4)	**Sometimes** (2)	**No** (0)
8.	Do you feel as though you cannot escape your tinnitus?	**Yes** (4)	**Sometimes** (2)	**No** (0)
9.	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies?)	**Yes** (4)	**Sometimes** (2)	**No** (0)
10.	Because of your tinnitus, do you feel frustrated?	**Yes** (4)	**Sometimes** (2)	**No** (0)
11.	Because of your tinnitus, do you feel that you have a terrible disease?	**Yes** (4)	**Sometimes** (2)	**No** (0)
12.	Does your tinnitus make it difficult for you to enjoy life?	**Yes** (4)	**Sometimes** (2)	**No** (0)
13.	Does your tinnitus interfere with your job or household responsibilities?	**Yes** (4)	**Sometimes** (2)	**No** (0)
14.	Because of your tinnitus, do you often find that you are irritable?	**Yes** (4)	**Sometimes** (2)	**No** (0)
15.	Because of your tinnitus, is it difficult for you to read?	**Yes** (4)	**Sometimes** (2)	**No** (0)
16.	Does your tinnitus make you upset?	**Yes** (4)	**Sometimes** (2)	**No** (0)
17.	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	**Yes** (4)	**Sometimes** (2)	**No** (0)
18.	Do you find it difficult to focus your attention away from your tinnitus and other things?	**Yes** (4)	**Sometimes** (2)	**No** (0)
19.	Do you feel that you have no control over your tinnitus?	**Yes** (4)	**Sometimes** (2)	**No** (0)
20.	Because of your tinnitus, do you often feel tired?	**Yes** (4)	**Sometimes** (2)	**No** (0)
21.	Because of your tinnitus, do you feel depressed?	**Yes** (4)	**Sometimes** (2)	**No** (0)
22.	Does your tinnitus make you feel anxious?	**Yes** (4)	**Sometimes** (2)	**No** (0)
23.	Do you feel that you can no longer cope with your tinnitus?	**Yes** (4)	**Sometimes** (2)	**No** (0)
24.	Does your tinnitus get worse under stress?	**Yes** (4)	**Sometimes** (2)	**No** (0)
25.	Does your tinnitus make you feel insecure?	**Yes** (4)	**Sometimes** (2)	**No** (0)

The sum of all your responses is your THI Score >>

0-16: Slight or no handicap (Grade 1)
18-36: Mild handicap (Grade 2)
38-56: Moderate handicap (Grade 3)
58-76: Severe handicap (Grade 4)
78-100: Catastrophic handicap (Grade 5)

This form is for informational purposes only and should not take the place of consultation and evaluation by a healthcare professional.

Please notify us if your insurance changes and complete a new form

It is your responsibility to understand your insurance, we gladly bill for you but we cannot know all the plans for every provider. We will on the best of our understanding bill you as directed. If your insurance does not pay , we will send a bill. All HMO plans must have an authorization before you can be seen. Some Advantage plans may have 2 copays, this is a change to what we expected from last year.

- ☐ I have Medicare part B. It pays 80% of the allowable rate after your deductible is met.
- ☐ I have a Medicare supplement plan _____ this should pay the remaining 20% unless you have a plan with a deductible and/or a copay. If your plan is an HMO supplement, we are out of network. Annual deductible $240
- ☐ I have VA CHAMP/ Community Care, referral needed # _____
- ☐ Tricare East we are a non-network participating provider, patients will owe 25% of allowable rate.
- ☐ Blue Cross Blue Shield all plans except the Select plan, HMOs require authorization _____
- ☐ Aetna all plans except CVS, specialist copay due at visit, _____
- ☐ Freedom/Optum HMO referral needed for service _____ copay _____

We are out of network with all other insurance plans. This worksheet will help you understand what your bill may be. Please check your plan. If incorrect information is given, the correct information will be on your bill. Please check your plan information in the book your insurance sent. We can bill electronically for out of network benefits as a courtesy and will reimburse if you have been overcharged. We are happy as well to email you superbills the next day.

- ☐ I have an **HMO** or **EPO** plan. There is no coverage or benefit with one of these plans. We will charge you the cash rate. If you get an authorization from your PCP for medical necessity to particularly see Dr. Michael Jonathan Clark because of his unique services and the inability to find another provider, you may be able to get reimbursed.

- ☐ I have a **PPO commercial** plan. I understand Island ENT is an out of network provider. My copay is _____. If you do not know your copay and we bill the insurance; they will tell us. My deductible is _____. I understand that my deductible must be met before my insurance will pay anything towards my bill.

- ☐ I have a **PPO medicare advantage** plan. I understand Island ENT is an out of network provider. My copay is _____. My deductible is _____. I understand that my deductible must be met before my insurance will pay anything towards my bill and OON doctors may have higher copays. These plans do have medicare limiting charges and this will be reflected in the bill.
- ☐ I prefer to pay **cash**.
- ☐ Workman's Compensation

Medicaid and Dual Access Cards We are not in network, All clients are required to pay cash and in the case of Medicare Dual the 20% remaining of the allowable amount. Sign _____

Insurance company _____ ID_____

Secondary _____ ID_____

Print Name _____ Sign_____

Witness _____ Date _____

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